THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

APRIL, 1948

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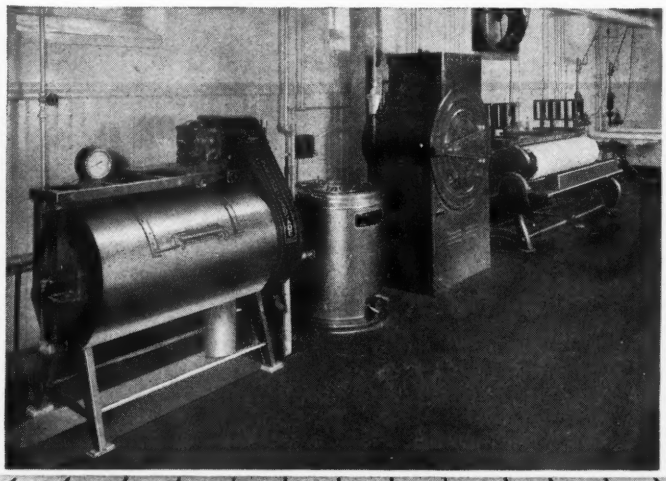

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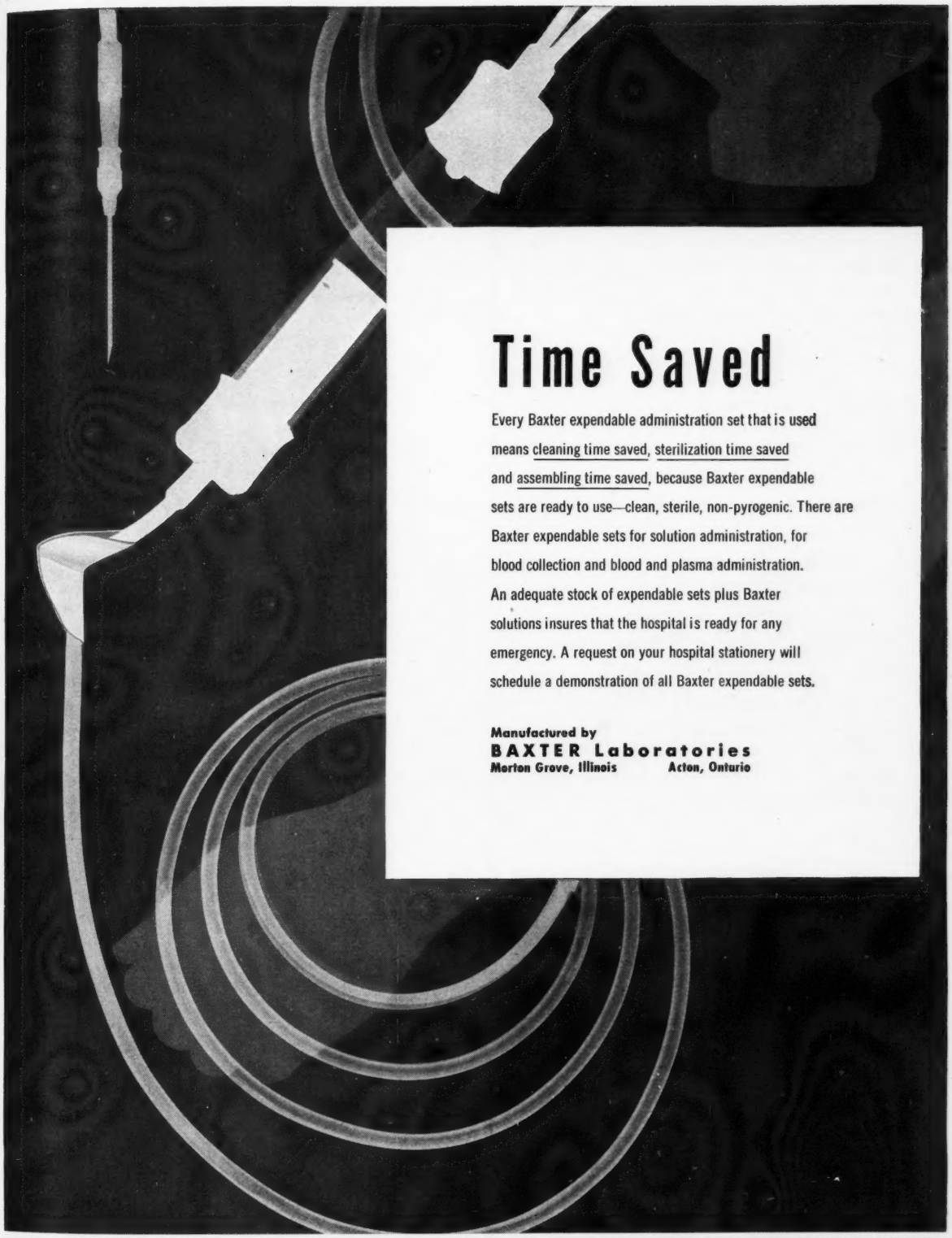

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Contents

Vol. 25 **APRIL, 1948** No. 4

Canadian Hospital Council

The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

EDITORIAL OFFICES: 280 BLOOR ST. WEST, TORONTO 5, ONT.

CCAB BNA

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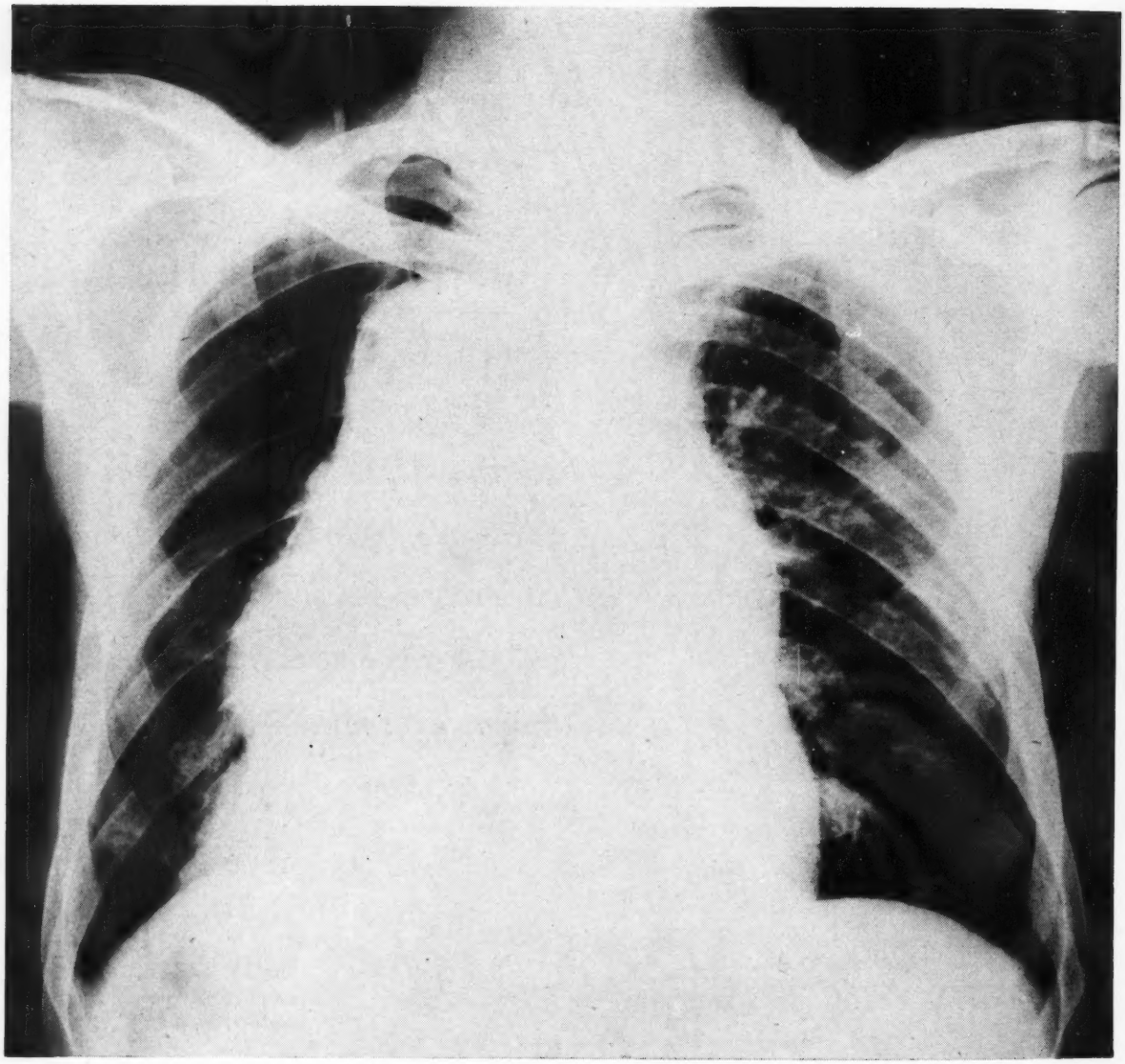
eyes *that see into the*



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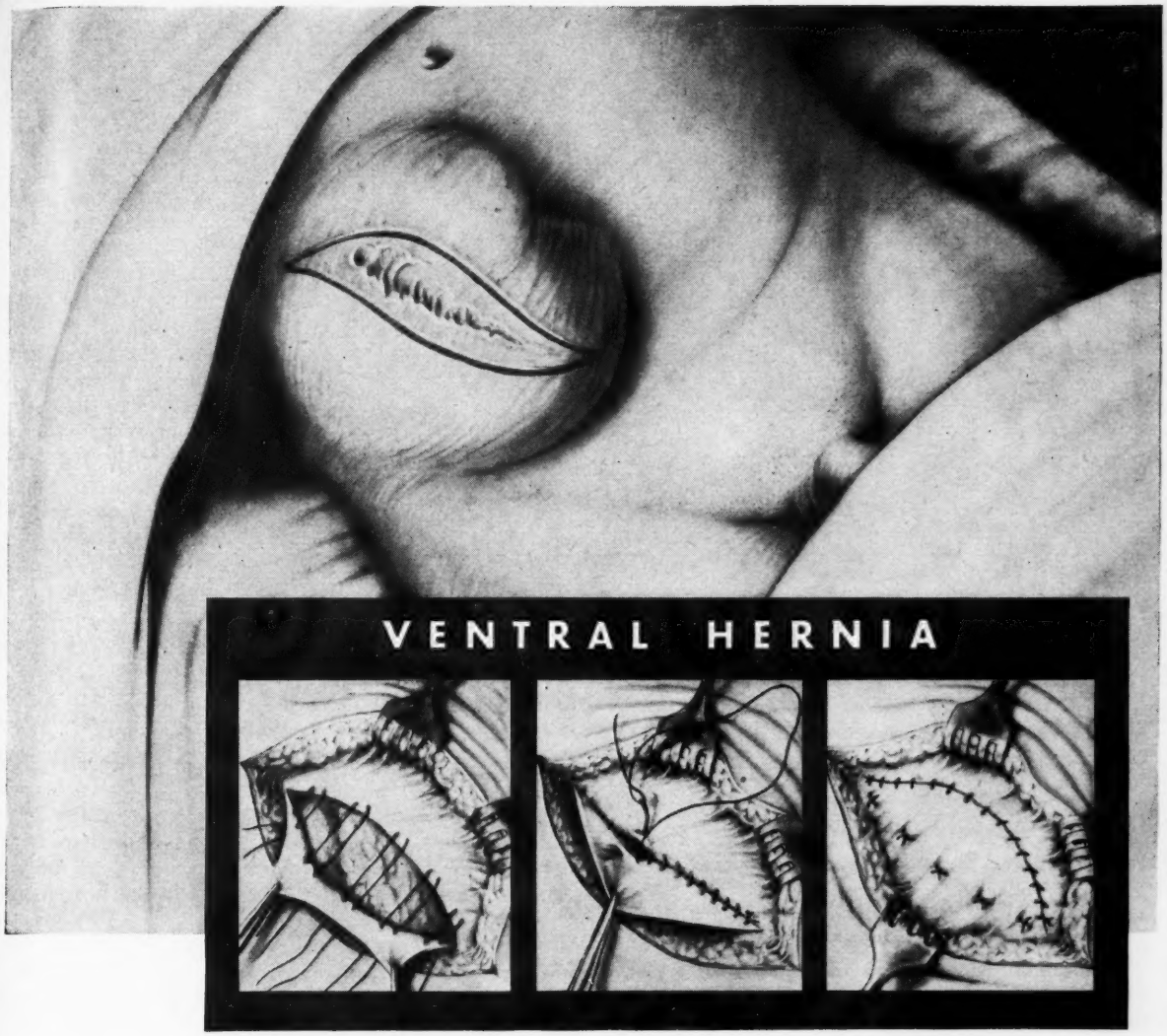

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Across the Desk

By C. A. E.

Charles T. Riall

Davis & Geck, Inc., manufacturers of sterile surgical sutures, announces the appointment of Charles T. Riall as Advertising Manager. Joining the company in 1929, Mr. Riall served in various capacities and became affiliated with the Advertising Department in 1944. Widely known in medical advertising and printing circles, he is a member of the Pharmaceutical Advertising Club.

* * * *

New Dustbane Products Catalog

A very attractive new catalog has just been issued by Dustbane Products Limited, Ottawa. Forty years experience in the manufacture and distribution of quality guaranteed products has given this old Canadian company an expert knowledge as to the most efficient manner in which to serve their many customers in the institutional field.

Detailed information is given describing their many products such as: cleaning equipment and supplies, deodorants, disinfectants, floor maintenance machines, floor polishes, insecticides, paper goods, soaps and cleansers, toilet soaps and sweeping compounds.

Dustbane Products Limited will be glad to send a copy of their catalog to you on request.

* * * *

Pre-War Rubber Floor Covering Returns

Re-entry to the market of pre-war flexible rubber runners has recently been announced with immediate delivery from present date. Popular before the war with hospitals, schools, industrial plants and other manufacturing and non-industrial institutions, this product is mainly used as a silent floor protector on ramps and hallways.

Moulded construction featuring corrugated ribs, 100 to the foot width on the top surface, gives smooth traction. Good weight and smooth undersurface cause it to lie flat at all times without curled edges. This smooth under-surface helps it hug any type of flooring and will not mar the natural finish.

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This product is distributed by Gordon A. MacEachern, 15 Elm Street, Toronto.

(Continued on page 16)

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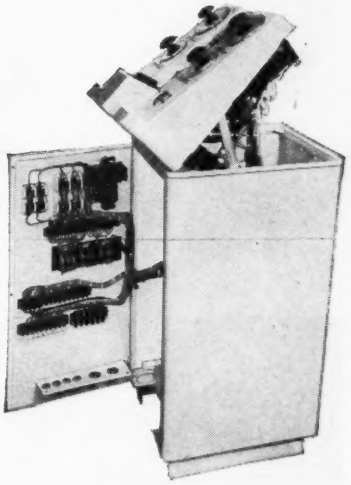

Multicron Capacities

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200 MA — 120 PKV
300 MA — 140 PKV
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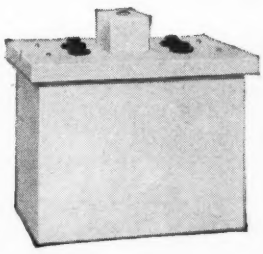

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Across the Desk

John D. Gwynne

Mr. Douglas F. Kent, General Manager of the Kendall Company (Canada) Limited, announces the appointment of Mr. John D. Gwynne to the position of Canadian Field Sales Manager of both the Bauer and Black Division and the Kendall Mills Division of the Kendall Company (Canada) Limited. This well known organization makes a wide range of products for the hospital field.

* * * *

C.G.E. Film Library

One of the largest industrial film libraries in Canada is described in a 20-page booklet recently issued by Canadian General Electric Company. It describes over fifty 16mm.-films, covering a wide variety of non-commercial subjects and available on a free-loan basis.

One of the subjects is entitled "Taking the X Out of X-Rays". This film shows, in a clearly understandable manner, the development and current usage of the x-ray. Not only has the x-ray been a boon to humanity as a diagnostic medium in both medicine and surgery, but has found a wide field of use in industry. The story of x-rays is told in this film by Dr. William D. Coolidge, the well-known General Electric scientist.

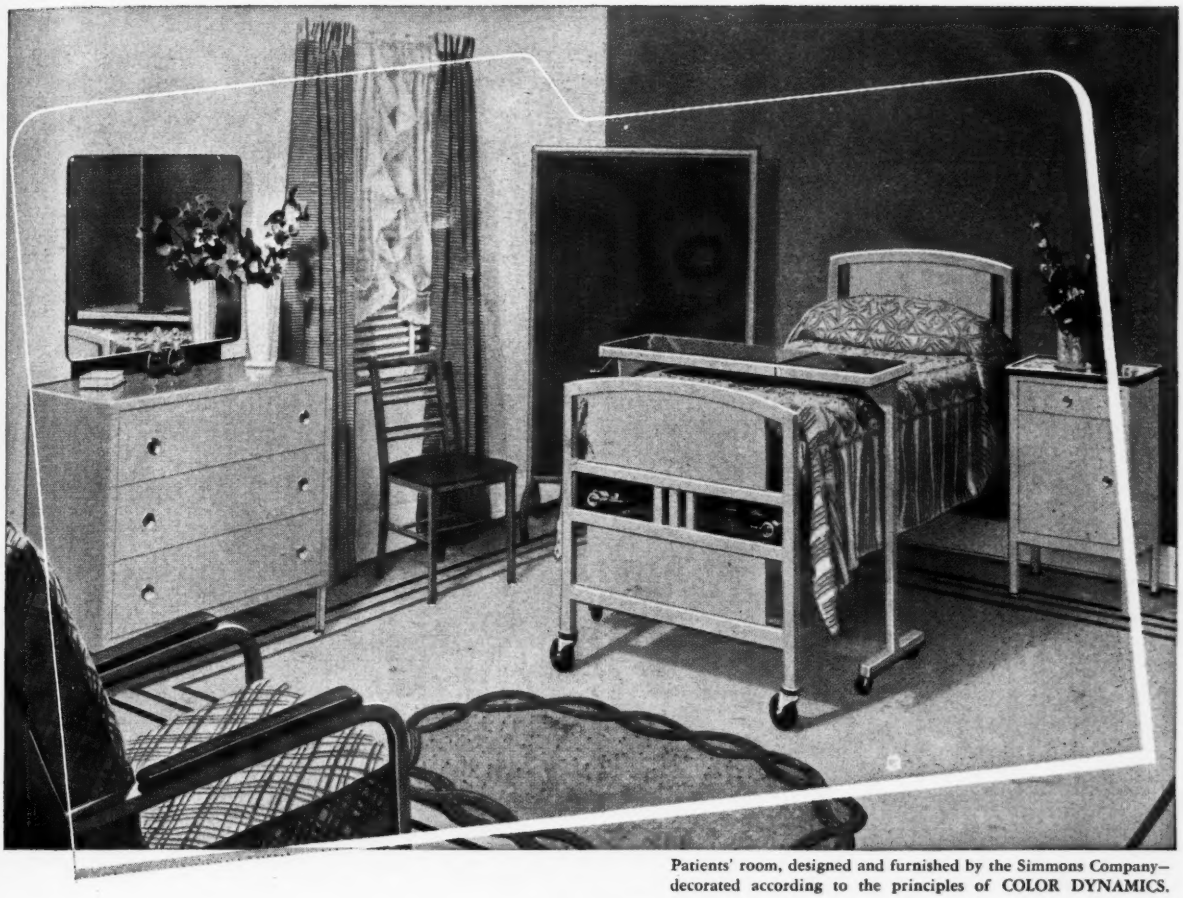
* * * *

Associated With Thomas Gibson & Company

Mr. T. Frank Slattery, Manager of the Northern Ontario operations of Thomas Gibson & Company Limited, specialists in hospital sanitation, has recently been appointed a director of the company.

Mr. Slattery has had many years' experience in dealing with hospital sanitation and floor maintenance problems and is recognized as being one of the best informed men in Canada in this field.

(Concluded on page 22)



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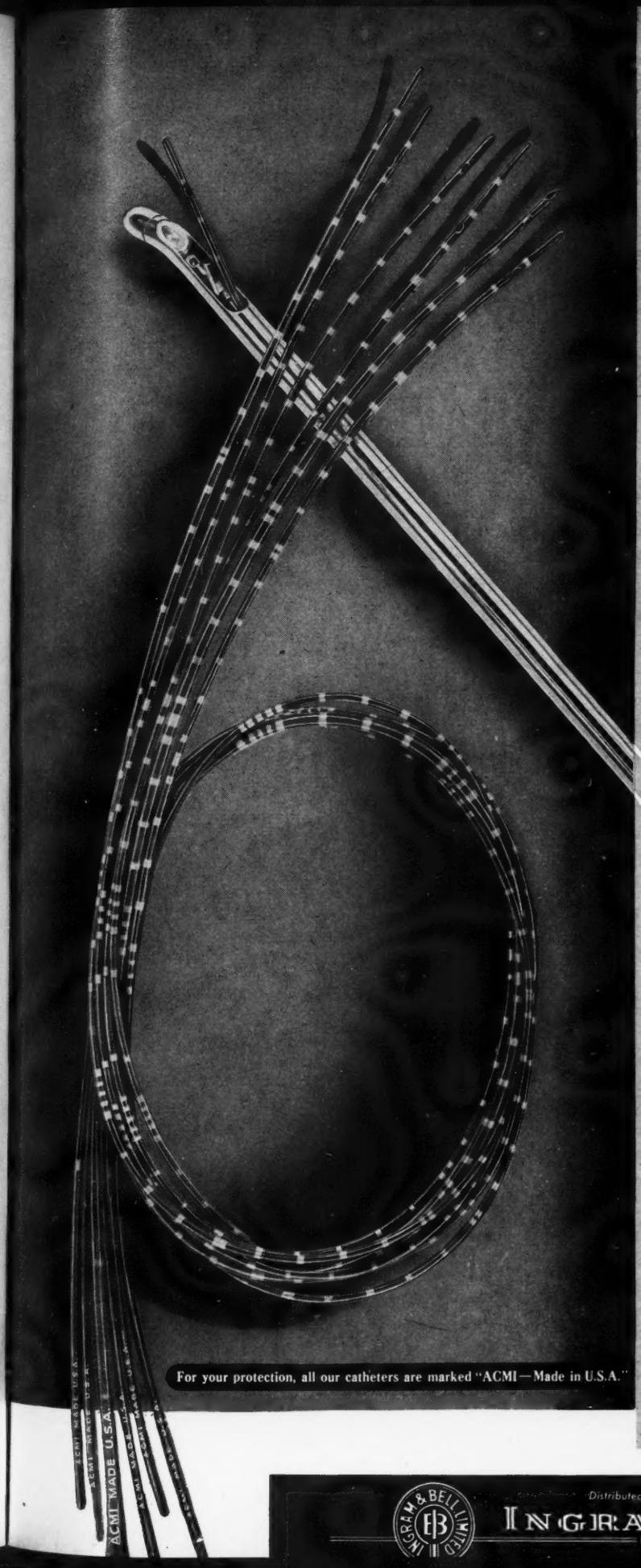

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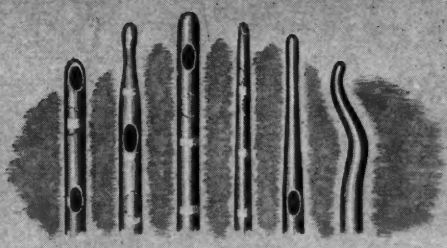

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Made Better

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Across the Desk *(Continued)*

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* * * *

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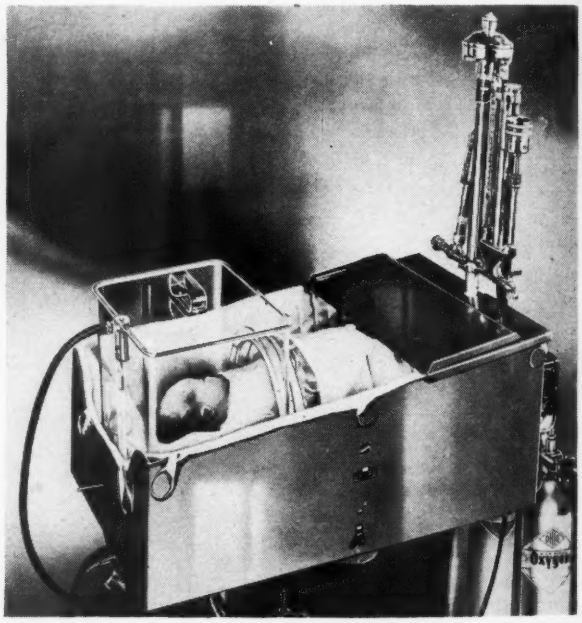
A new Kreiselman-model transparent-plastic tent-hood with a postive-acting safety device, for the administering of oxygen to infants, is announced by the manufacturer, The Ohio Chemical & Mfg. Co., Madison, Wis.



Leakage of oxygen is prevented by a removable skirt of pliable plastic tucked around the body of the infant and secured to the hood with an electric fastener. In case of failure of the oxygen supply, a safety valve automatically raises the hood cover, permitting circulation of atmospheric air within the hood.

The tent-hood is designed to be used in conjunction with any suitable oxygen-administering apparatus, and is shown here in use in a Kreiselman heated-bassinet resuscitator. The hood is supplied complete with oxygen-delivery tubing, five disposable skirts and an elastic fas- of atmospheric air within the hood.

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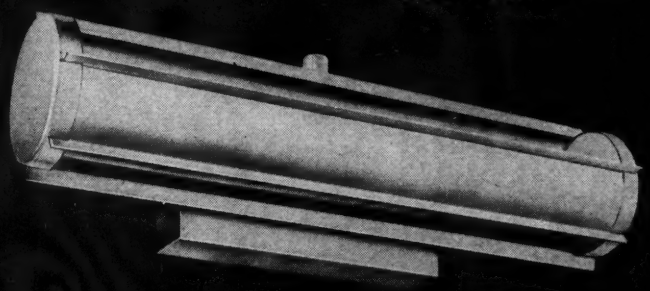

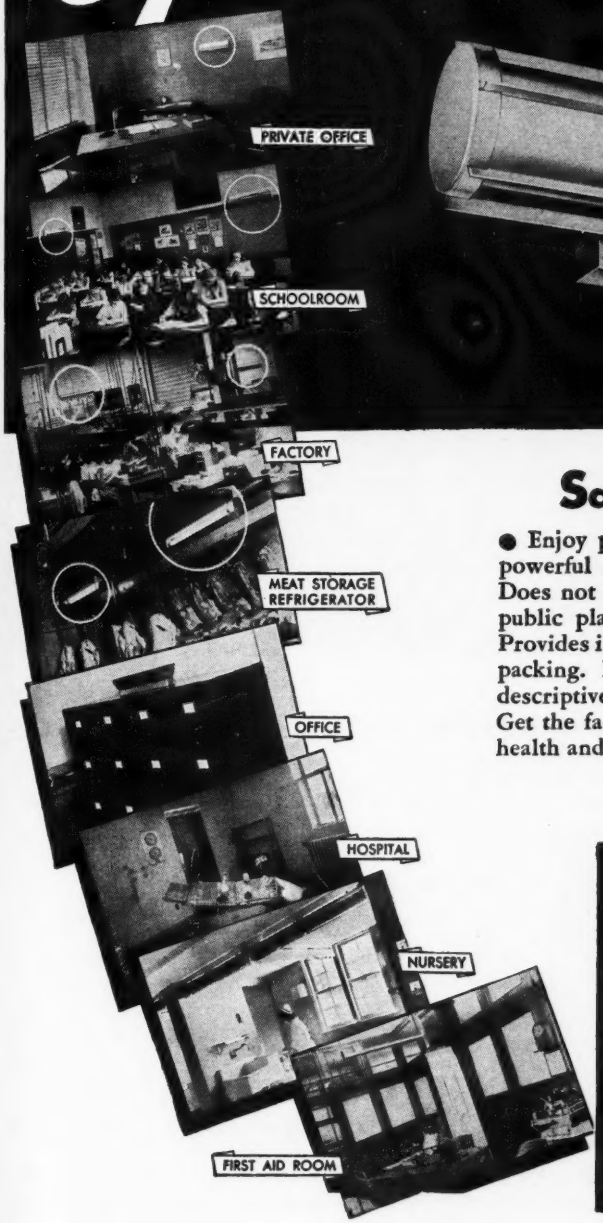

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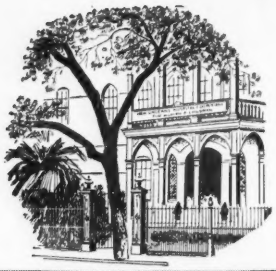

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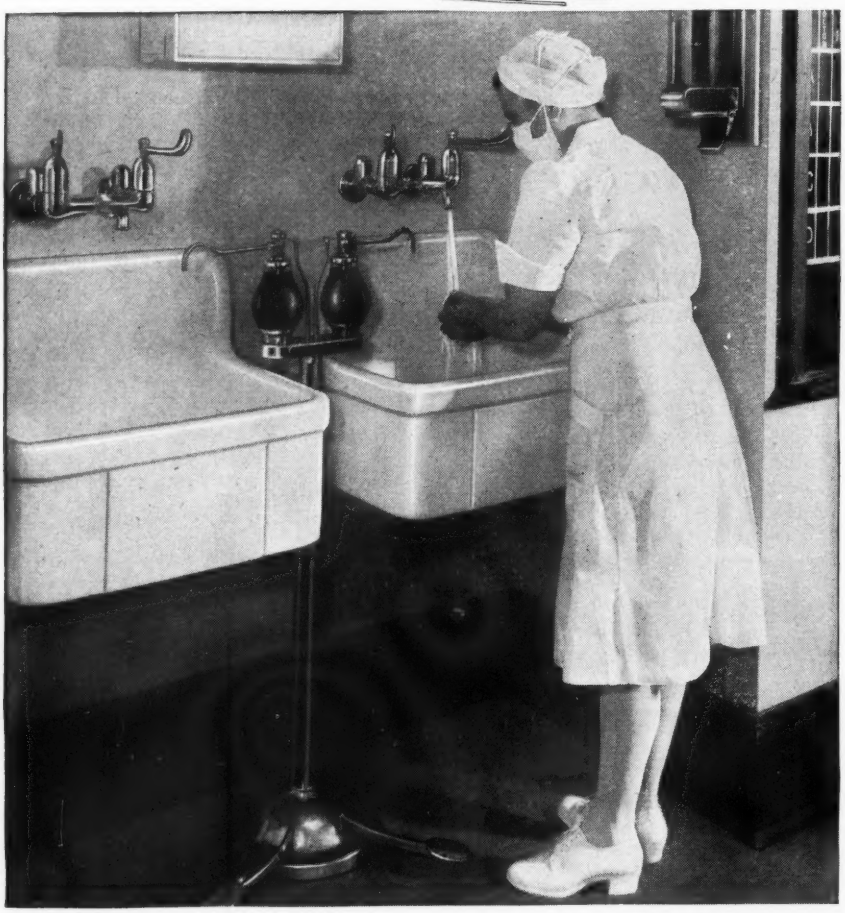

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, April, 1948 Vol. 25 No. 4

Whose is the Responsibility for Maintaining an Adequate Supply of NURSES?

By the Editor

MANY people across this country are deeply concerned over the obvious inadequacy of present efforts to provide nursing service which will effect a long range solution of present shortages. It is becoming more fully realized by those concerned with the welfare of the sick, that we are now fighting a losing battle, and that *our situation a decade hence bids fair to be much worse than it is today.*

It is not enough to point out that there are fifty per cent more student nurses enrolled now, (12,880 in January, 1947) than there were in 1939 (8,416). That advance must be weighed against the relatively greater increase in the demands for the services of nurses and the ever widening fields of employment. The proportion of graduates remaining in hospital work, either in salaried positions or as special duty nurses, is steadily dropping. In recent years industry has absorbed a tremendous number of graduates. In March 1943, there were 1,356 nurses employed in industry and the number is increasing steadily. With more unions now insisting that the provision of nurse service be included in contracts, and with the hours of work being steadily reduced, this movement to industry may well be maintained and even accelerated in the coming years.

Public health is absorbing more nurses every year. In 1943 there were 1,885 nurses so employed. We are informed that there is now a shortage of some 500 public health nurses and that an additional 1,800 will be required for proposed developments. Where will these 2,300 nurses come from? If the Dominion-Provincial taxing structure is satisfactorily adjusted and large sums of federal money become available for public health activities, the demand will be still greater.

Other factors adding to the shortage of nurses must be considered. Shortened working hours in hospitals as well as in industry means that more personnel is required to perform a given amount of work. With reduced housing accommodation and more women at work, more illness is being hospitalized. With a maximum utilization of beds (and the shortage of beds will persist for years) the average patient is more

"It should be clearly realized by all that the hospitals alone cannot continue to assume the responsibility for maintianing an adequate supply of nurses in this country."

acutely ill and in hospital for a shorter time; this means more nursing per patient-day. The present-day crowding of hospitals has made it difficult to determine if hospital care plans have been much of a factor in promoting hospitalization, for conditions are equally bad where these plans do not operate, but, if more beds do become available, undoubtedly there will be increased utilization and, therefore, greater demands upon nursing service. Many doctors use nurses for all kinds of tasks in their offices.

It is apparent, therefore, that the demand for the services of nurses will increase tremendously and that the output of nurses must be augmented far beyond present production levels.

If, by the stroke of a magic wand, the many thousands of badly needed hospital beds could be provided overnight, the vast majority of these beds could not be put into use—for the simple reason that there are not enough nurses and other trained staff to look after the patients.

National Emergencies

Of particular concern is the likely inability of our present supply of nurses to meet major national emergencies. Were a serious epidemic of nation-wide extent to break out there would not be sufficient nurses to care for the patients either at hospital or in the home. Were war to break out, and one quarter or more of our nurses enlist or be called up, it might well be necessary to close down wards containing in the aggregate many hundreds and probably thousands of our present hospital beds. In either case the resulting situation would constitute a veritable national calamity—and we use that phrase advisedly.

Health Insurance

There are many indications that most of our governments—provincial and federal—are becoming steadily more interested in health insurance, and that other provinces may join those which now have complete or partial plans when the taxing structure is finally adjusted, particularly if such adjustment should co-incide with a major depression or a general election.

We question if it is fully realized that no really comprehensive plan of health insurance providing hospital care, home nursing and public health nursing, could be put into operation without first developing the nursing and other personnel to provide these services.

Corrective Measures to Date

What has been done to meet these demands? Our 169 schools for nurses have done what they can do to maintain peak enrolment. Many have enrolled nurses beyond the normal capacity of the school. Governments and nurses' associations have set up schools for practical nurses (nurse assistants) and hospitals using these assistants have delegated many tasks formerly done by graduate nurses to these and other ward aides. At Windsor, Ontario, a four-year experiment with a shortened course in a school separated financially from the parent hospital, is being conducted by the Canadian Nurses' Association with the financial assistance of the Canadian Red Cross Society. This will indicate whether a two-year course from which non-educational duties have been largely eliminated is adequate. It should reveal, also, whether this type of training costs more than the conventional three-year apprenticeship type of training and, if so, how much.

In Manitoba a representative committee named by the Minister of Health has studied the situation with special emphasis upon the provision of nursing service in the rural areas. The provincial hospital and ladies' aids associations are now working on a recruitment program.

Solution Not in Sight

Do these measures constitute sufficient action? In our opinion they do NOT.

Some 169 schools, no matter how they crowd their classrooms, cannot meet the steadily increasing demand of industry and public health as well as supply the civilian hospitals, the huge D.V.A. hospital chain which trains no nurses, and supply the heavy export market to the United States as well as the marital market. It has become an impossible task.

Practical nurses, despite free tuition and pay while learning, are not being prepared in sufficient numbers as yet to provide any appreciable solution to the problem.

The Windsor demonstration school may well prove the efficacy of the two-year basis of uninterrupted training, but it would still be a long time before nursing schools, as a whole, could be expected to change over from the three-year course. And if the study proves after four years that a subsidy may be needed to compensate the hospital for lost student services, more valuable time would be lost before adequate governmental support could be obtained.

It must be obvious to all thinking people that these efforts to meet the situation, excellent and commendable though they are, must not constitute the sum total of the efforts to be made during these critical years.

Suggested Solutions

Various suggestions have been made for effecting a more permanent solution. Some would seem more practicable than others and some might be more effective in the overall solution:

1. Schools might be established in other and smaller hospitals. This does not appeal to those who realize how this would limit the training and experience of the students. The smaller schools now have most difficulty in filling their classes and, of prime importance, there is a marked shortage of properly qualified instructors.

2. Some of the present schools might handle more students by sending them to smaller hospitals for much of their practical work and by using the base school largely for the academic work. This, of course, would add to the cost of the parent hospital and school, and financial assistance would be required. This possibility has received favourable consideration by a special governmental committee in Manitoba, although we understand that it has not

yet been approved by the larger hospitals.

3. More practical nurses might be trained to supplement the graduate and student staff. Unfortunately, the number of available practical nurses is quite inadequate. Assistance is needed here to popularize this field.

4. Schools of nursing might be centralized as in other fields of education, the hospitals being utilized to provide practical experience. This would mean governmental or municipal assistance. While many support this idea, some feel that this development would need careful study lest such essential factors in the nurses' preparation as self-discipline, devotion to the patient, and many intangibles of the nurses' training be lost.

5. Higher salaries have been suggested, for nurses still must take their turns at night and on Sundays and holidays. Actually, gross salaries in most hospitals are now commensurate with those paid in industry. More nurses could be obtained by outbidding industry, but this would necessitate the subsidizing of hospitals, and it would only mean a redistribution—not a lasting solution.

6. Attention has been focussed on the wastage in hospitals of the nurse-hour services of skilled nurses by requiring them to do tasks which could be done by others. It has been stated frequently that this wastage of the time of skilled nurses is much greater in industry. One example is their retention as air-stewardesses by Canadian lines, "the only country using graduate nurses", as one person put it "to peddle chewing gum."* And it would seem to be so in the case of many public health nurses, a number of whose assignments could be done by others less highly trained. Other employers of nurses, as well as the hospitals, might well check on the wastage of nurse-time on their own staffs.

7. There are many who believe that the whole system of providing nurse care should be reorganized. Duties should be reassigned, nurses' educational requirements should be revised, and recognition should be given to two levels of training, the two-year graduate and the four-year graduate of a university-linked school. On these points there is no unanimity.

8. Others are of the opinion that the availability of married nurses for part-time duty would be greatly increased if the wartime exemptions from income tax applicable to married women's incomes could be restored.

9. Various other suggestions have been made, such as: co-operative programs for nurse recruitment; the licensing of all who nurse for hire; minimum standards for student accommodation; more extensive extra-curricular recreational programs for student nurses; less adverse publicity respecting long-since corrected conditions of work in hospitals; better collective bargaining on a regional basis; et cetera. Like the other suggestions enumerated, these should be given careful consideration by a competent study group.

While temporary palliatives can be applied, and are being applied, without too much difficulty, it will not be easy to effect a lasting solution.

Opinion is divided among members of the nursing profession respecting nurse-stewardesses, some being of the opinion that this arrangement has recruitment value and may be desirable in case of a major depression.

We question if it is fully realized that no really comprehensive plan of health insurance providing hospital care, home nursing and public health nursing, could be put into operation without first developing the nursing and other personnel to provide these services.

Extensive Survey Needed

The Joint Committee, representing the Canadian Nurses' Association, the Canadian Hospital Council, the Canadian Medical Association and the Department of National Health and Welfare, has come to the conclusion that the whole subject must be studied from every angle—the present need, the available supply, the present system of education, the likely needs in the future, and present and future economic factors. Recommendations must be brought in which, if applied, would really solve the problem for many years to come—not merely provide temporary relief for the next few years.

Whose is the Responsibility?

But whose responsibility is it to work out a long-range and lasting solution? Is it that of the nurses?

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Is Recovery Delayed by Inadequate Diets?

{ *Danger of Insufficient Calorie and Protein Intake* }

Mary M. Harrington, M.A.,
Director of Dietetics,
Harper Hospital,
Detroit, Michigan.

OFTEN it has been said that "the way to a man's heart is through his stomach". The efforts of the dietitian have always been directed toward providing attractive, palatable, meals to patients and to filling dietary prescriptions. Her professional knowledge was sought primarily by the paediatricians and internists, but surgeons have become increasingly interested in nutrition. The way to a surgeon's heart has been through his interest in maintaining good nutrition to patients who have had, for instance, gastric or intestinal resections. Surgical journals are now carrying an increasing number of scientific articles which emphasize the nutritional status of the patient. One particularly outstanding metabolic study on "total gastrectomy: effects upon nutrition and haematopoiesis" reported by Farris, Ransom and Coller, shows the degree of utilization of the various food stuffs.

Daughtry states that "post-operative care is really a continuation of pre-operative care, but often the surgeon is so preoccupied with the disease that some details are entirely overlooked. Food, water, minerals and vitamins are indispensable in good pre- and post-operative care." He suggests that solid foods may be tolerated much earlier than realized, and will often reduce the incidence of distension and cramps. It is interesting to note that, following an operation, patients are no longer given clear fluids without food value for a long period of time, nor a very restricted soft diet, but are given full diets with a choice of foods as desired by the patient.

Bensley, in the *Nutrition of the Surgical Patient*, has made some very pertinent suggestions: "Malnutrition among surgical patients in the past had become so common as to constitute the rule rather than the exception. This malnutrition had seriously delayed recovery in many cases, and in some had been a cause of post-operative death. This can be prevented or corrected by painstaking and detailed attention to the food intake of the patient. There is often a wide difference between what the physician thinks the patient eats and his actual intake."

The surgeon has shown increasing interest in nutrition, but greater attention on the part of all physicians is necessary if we are to improve the health of our people.

In 1942 I wrote in one of our bulletins: "Nutrition is the cornerstone of health . . . A full realization of this truism makes it incumbent on the physician to promote an optimum state of nutrition in every patient by insisting on an adequate diet undistorted by the whims of appetite. From the point of view of a co-worker in the field of medicine, the prime responsibility rests on the shoulders of the medical profession. This group must accept the challenge by studying nutritional defects in the food habits of the patient, and by teaching the fundamentals of this science in terms of food."

Calories and Proteins Essential

In 1946 Youmans, in the Shattuck lecture on "Nutrition and the War", emphasized that the two nutritional factors which had assumed a new and important place in clinical medicine during the war were calories and protein. These were really emphasized in 1897 by Shattuck, when he recommended large amounts of food for patients with typhoid fever. Youmans raises the question as to "why the medical profession, with its successful experience in feeding patients with typhoid fever before its eyes, has been willing to accept the severe weight losses and delibility accompanying other infectious diseases and illnesses as a natural and inescapable concomitant of these diseases."

All too often medical treatment concerns itself with medication, surgery and other procedures without any investigation or consideration as to the nature of the food intake of the patient.

Perhaps the emphasis on nutrition has been one-sided in that minerals and vitamins have received more recognition than all the other factors essential for the maintenance of health. Calories, protein, carbohydrate, fat, and fibre, are equally as important. Even when all of these factors have been considered, there remains the personal equation of taste and appetite as influenced by environment, as well as social and economic status.

Caloric intake is important in maintaining an optimum state of nutrition in the surgical patient. Life expectancy decreases and the incidence of certain diseases increases proportionately when body weight is excessive. The orthopaedic surgeon is often concerned with weight control when the patient is to have a long period of inactivity and is confined by a body cast. Insufficient caloric intake, unless the diet is carefully planned, will result in a protein deficiency. Youmans emphasized that "caloric and protein deficiency disease is one of the most frequent of all nutritional deficiencies in practice."

Protein starvation results quickly when the calories are insufficient unless the protein of the diet is maintained at a high level, because adequate caloric intake has a sparing action on protein. However, recent studies during the war have shown that, even when the caloric intake has been adequate, protein deficiency has been demonstrated by a negative nitrogen balance in injury and di-

An address at the Toledo Regional Conference of the American College of Surgeons in January.

sease. This has been evident in fractures of the long bones in previously healthy persons and is well established in infections showing a high temperature. A serious deficiency results more quickly if the caloric intake is insufficient and results in marked weight loss, muscle atrophy, weakness and poor healing of wounds. This nitrogen loss is usually through urinary excretion, but may occur in exudates or drainage from wounds and the surface of burns. Thompson, Ravdin and Frank, showed the necessity for a high protein intake in order to produce healing in wounds, and this work has been confirmed by many others.

New methods of study and treatment have led the surgeon to the use of protein hydrolysates, pre- and post-operatively, to spare the body protein, but Cannon states that tissue protein may not result unless all the essential amino acids are present in adequate amounts and in the correct proportions. Complete utilization of these amino acids, however, still depends on the efficiency of the synthesizing mechanism and he states further that, if these cells have free access to an available supply of energy, vitamins and necessary minerals, and if they have not been injured by "conditioning factors", conditions should be optimal for effective utilization. However, Cannon feels that "this does not imply that high quality natural protein should not be fed whenever possible, particularly for reasons of palatability and economy".

Usually, when the caloric and protein need is greatest, food is necessarily restricted by the surgeon, or the patient has little or no desire to eat. Lund and Levenson show "that the surgeon must realize that the most important and most frequent factor in protein deficiency is due to an inadequate intake of food". Patients seek the surgeon because of illness or injury, and the psychological and physiological involvement usually results in diminished intake, due to loss of appetite or emotional tension. Negative nitrogen balance, due to insufficient intake, is further increased, due to internal or external exudates from wounds, continuous bleeding, diarrhoea, vomiting, or by a marked elevation in body temperature due to the infectious processes. The patient may have an already depleted body protein, and increasing nitrogen loss may have serious effects in a short period. Therapeutic measures are necessary to replace the initial deficiency plus the accelerated loss caused by illness.

Intravenous feedings of glucose and the essential amino acids may be beneficial in the acute stage, but can be continued for only a short period of time. Protein hydrolysates are expensive for oral feeding, and are not particularly palatable. A prescription of a particular hydrolysate order as ½ oz. q. 2 hours for 6 feedings, as an addition to the diet, costs $1.63 per day in our hospital, but this item could be replaced by powdered skim milk in a palatable form for 23 cents. The measures

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L'Importance du Régime dans la Convalescence

LA préparation d'un régime et la présentation de mets attrayants et agréables au goût constituent une des principales fonctions des diététistes. Médecins et pédiâtres ont recouru les premiers à leurs services professionnels; aujourd'hui, les chirurgiens reconnaissent également la nécessité de maintenir un bon équilibre nutritif chez leurs opérés, en particulier, dans les cas de résection gastrique ou intestinale. Les revues chirurgicales abondent en communications scientifiques présentées en ce sens. Entre autres, Farris, Ransom et Coller, dans une étude remarquable des conséquences de la gastrectomie totale sur la nutrition et l'hémapoièse, ont démontré le degré d'utilisation des divers produits alimentaires.

Daughtry déclare que les soins post-opératoires ne doivent être, en réalité, que le prolongement des soins pré-opératoires. Un bon équilibre dans la répartition des aliments, des breuvages, des sels minéraux et des vitamines est èssentiel, après comme avant l'opération. C'est une notion que les chirurgiens, pré-occupés par la gravité des lésions, ont souvent tendance à oublier. Il rappelle que les aliments solides sont tolérés beaucoup plus tôt qu'on ne le croit généralement et qu'ils réduisent considérablement la fréquence des spasmes et de la distension.

On ne garde plus aujourd'hui les opérés sous un régime hydrique sans valeur nutritive et, très tôt, on fait absorber à ces patients les aliments de leur choix.

Bensley, dans son travail "Alimentation de l'opéré", note qu'autrefois une mauvaise alimentation constituait la règle plutôt que l'exception, en chirurgie. Comme résultat d'un régime mal balancé, la guérison était retardée dans la plupart des cas, quand l'issue n'était pas fatale. Ces résultats malheureux peuvent être évités par une meilleure attention apportée à la nourriture ingérée par le patient.

Tous les médecins devraient se faire un devoir de mieux étudier, chez leurs patients, les déficiences nutritives et ils devraient enseigner l'application d'un sain régime alimentaire.

Calories et Protéines

Youmans, en 1946, dans une conférence intitulée "La guerre et la Nutrition" insistait sur les deux grands facteurs de l'alimentation: les calories et les protéines. Dès 1897, Shattuck recommandait une alimentation abondante chez les typhiques; aujourd'hui, Youmans se demande jusqu'à quel point les pertes considérables de poids et la débilité marquée que l'on rencontre dans les autres maladies infectieuses seraient le résultat d'un régime insuffisant.

Très souvent le traitement médical se confine à une prescription médicamenteuse ou à une intervention chirurgicale, sans considération de l'élément nutrition. Récemment, on a peut-être attaché plus d'importance aux sels minéraux et aux vitamines et on a négligé, semble-t-il, la quantité des calories, les protéines, les hydrates de carbone et les graisses qui constituent des facteurs égale-

ment de première valeur. Il faut, de plus, considérer la personnalité des patients dont les goûts, l'appétit, le milieu social et la situation économique peuvent jouer une influence considérable dans le régime.

L'apport en calories joue un grand rôle dans le maintien de l'équilibre nutritif optimum chez l'opéré. La durée probable de la vie diminue et la fréquence de certaines maladies augmente en raison de l'excès de poids du corps. Le chirurgien orthopédiste connaît très bien les complications qui menacent son patient maintenu inactif dans un plâtre pendant une longue période. D'après Youmans, la déficience en protéines et en calories constitue une des plus fréquentes erreurs alimentaires dans la pratique médicale. Lorsque la quantité des calories est inadéquate, il s'ensuit habituellement une diminution des protéines; de plus, même avec un nombre insuffisant de calories le déquilibre du Métabolisme de l'azote, au cours d'une maladie ou à la suite de blessures graves, entraîne une déficience des protéines, comme l'ont démontré des recherches scientifiques pendant la guerre. A la suite d'un manque de calories, on note une perte de poids, de l'atrophie musculaire, de l'asthénie et un retard dans la guérison des lésions. Les travaux de Thompson, de Ravdin et de Frank ont prouvé la nécessité d'un apport adéquat de calories.

En vue de protéger les protéines de l'organisme, les chirurgiens emploient couramment aujourd'hui, avant et après l'opération, des protéines hydrolisées. Cannon prétend que les tissus ne bénéficieraient de ces protéines qu'en autant que tous les acides aminés essentiels seraient donnés en quantité et en proportion adéquates et encore l'utilisation de ces acides aminés dépendrait de la valeur du mécanisme d'absorption dans les tissus.

Il arrive bien souvent, malheureusement, que le chirurgien doit restreindre l'alimentation alors que les besoins en calories et en protéines sont les plus marqués et que le patient éprouve plus ou moins d'appétit. Le chirurgien ne doit pas perdre de vue qu'un apport inadéquat de nourriture entraînera une diminution marquée de protéines. Ce désiquilibre sera encore accru par les exsudats internes et externes des lésions, par une hémorragie, par de la diarrhée ou des vomissements ou encore par une élévation marquée de la température du corps par suite du phénomène infectieux.

Une thérapeutique active devra donc combler le déficit protéinique causé par l'état initial et augmenté par la maladie. Des injections i.v., de glucose et d'acides aminés rendront de précieux services durant la phase aigue mais elles ne pourraient être prolongées bien longtemps. Les protéines hydrolysées sont coûteuses et désagréables au goût; Youmans recommande plutôt des aliments de choix, particulièrement riches en protéines.

SUGGESTIONS:

Régime de base

Lait

Une pinte par jour pour chaque enfant (en breuvage ou contenu dans les aliments cuits).

Une chopine par adulte (en breuvage ou contenu dans les aliments cuits).

Légumes et Fruits

4½ à 5 portions par personne, tous les jours.

Une portion quotidienne de pommes de terre ou de patates douces.

Une portion de tomates ou de fruits acidulés.

Une portion quotidienne de légumes à feuilles, verts ou jaunes.

3 à 5 portions par semaine d'autres légumes.

Une portion de fruits, par jour.

Oeufs

2 à 3 par semaine pour les adultes, 4 à 5 pour les jeunes enfants, quelques-uns dans les aliments cuits.

Viande, Poisson ou Volaille

Environ cinq fois la semaine, ou tous les jours s'ils sont préparés combinés avec des céréales ou des légumes.

Céréales

Tous les jours—de préférence le blé complet.

Pain et Beurre

Pain brun (pain de son) ou pain fait de farine à pâtisserie, à tous les repas.

Dessert

Une fois par jour, deux fois si désiré et si ces desserts ne remplacent pas des aliments de base.

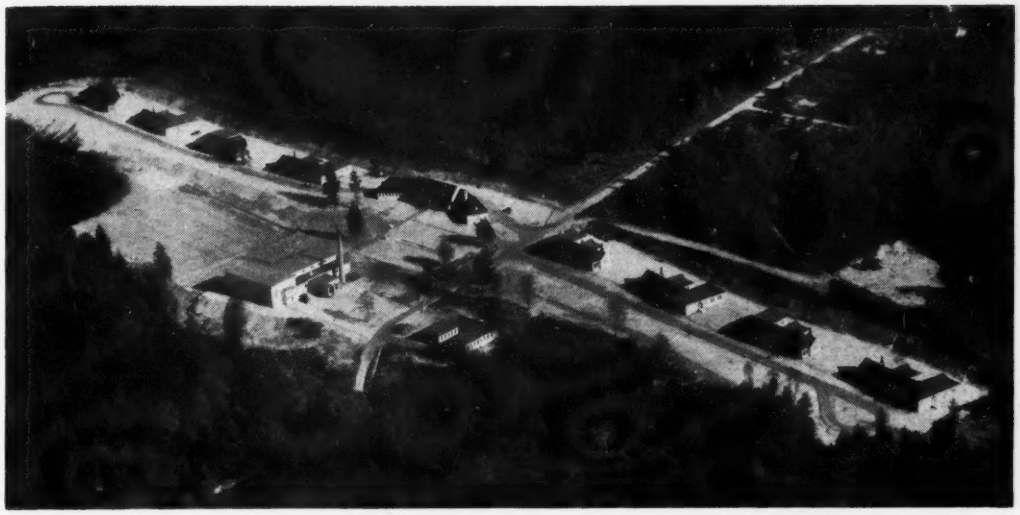
La quantité des calories est un facteur capital dans le maintien de l'équilibre des protéines tissulaires mais il ne faut pas oublier que la qualité des protéines joue également un rôle essentiel; les sels minéraux et les vitamines sont également indispensables. Une déficience en Vitamine A entraîne, selon Mellanby, des modifications de dégénérescence dans les nerfs et de la fragilité capillaire. D'après Cannon, la Vitamine B est aussi indispensable que les acides aminés et le nombre de calories. La réduction, dans l'organisme, d'une quantité considerable de Vitamine C, au début de la maladie et dans les premières heures qui suivent les brûlures, nécessite un apport plus considérable de cette vitamine.

Certains chirurgiens croient qu'un patient ne peut absorber toute la nourriture nécessaire pour répondre à ces besoins; c'est alors qu'une diététiste avisé et compétente peut rendre de précieux services. Elle présentera au patient, sous une forme condensée et agréable, tous les éléments essentiels au prompt recouvrement de sa santé.

(Bibligraphie Page 76)

Sound the Trumpet of Your Good Deeds on
NATIONAL HOSPITAL DAY

—Basil C. MacLean, M.D.



New Veterans' Health and Occupational Centre

A HEALTH and occupational centre is a new type of institution where treatment for convalescent patients is carried out chiefly by means of physical medicine and occupational therapy. It is one of the more recent advances in rehabilitation being used by the Department of Veterans Affairs to give veterans an opportunity of not only regaining their health, but also of obtaining instruction in various trades or of completing their education.

The George Derby Health and Occupational Centre* described in this article is a two-hundred-bed institution of the pavilion type, on a site overlooking Burnaby Lake, Vancouver Island, British Columbia, with the snow-capped North Shore mountains providing a distant background. The centre is comprised of an administration building, a treatment building, and eight twenty-four bed pavilions. These buildings are spread out over an area of 2,000 feet with ample space between. A central boiler house transmits steam heat through underground concrete tunnels and water is supplied by a 40,000 gallon tank.

With the exception of a dining room, each of the pavilions is self-contained. There is a comfortable lounge with an open fireplace, a large screened veranda, storage space in the basement for personal effects, laundry equipment and ironing boards for patients to take care of their own needs, as well as quarters for the supervisors.

The central administration building contains offices, dining room, kitchen, storage space, school room for classes, billiard room, library, bowling alley and canteen.

The treatment building houses the medical examining rooms, physiotherapy department, swimming pool, technical library, work shop, large waiting room, and an excellent auditorium with stage accommodations. The auditorium is also used as a gymnasium for games, badminton, concerts, dances and other entertainment.

Types of Patients

At present there are three main types of patients sent to the Centre. First, the elderly men of the Boer War and First World War. They are known as class "6" patients and are men who will be given institutional care for the remainder of their lives, if they so choose.

The second type are the arrested tuberculosis cases. They are all young men of the second World War, whose disease has reached a non-contagious stage. In order that they may have special rest periods, they are housed in a separate pavilion.

The third class includes all medical, surgical and orthopaedic cases. Under these headings are patients suffering from anaemia, stomach ulcers, arthritis and rheumatism. There are also post-operative cases of all kinds, those having fractures in plaster, disabilities resulting from gun shot wounds and a few industrial accident cases who are being treated by the Department of Veterans Affairs instead of the Workmen's Compensation Board.

Routine on Admission

Patients sent to this Centre are from either Shaughnessy Hospital, Vancouver, The Veterans' Hospital, Victoria, or Out-Patient Department, Haro Street, Vancouver. They are transported in the Centre's bus,

*Named after George C. Derby, Western Regional Administrator of the Department of Veterans Affairs.

usually arriving daily, about 4 p.m. The chief nursing orderly meets them and assigns them to their pavilion, according to their disability. The next morning they are documented, examined by the doctor, interviewed by the Supervisor of Institutional Training, and commence their treatment. From then on they are checked weekly by their doctor, more frequently if necessary.

Treatment

As all patients are walking cases and do not require nursing care, there are no nurses on the staff of the Institution. There are, however, a number of nursing orderlies who care for some of the elderly patients and the arrested tuberculosis cases. All treatment is under the direct supervision of qualified and skilled technicians in physio-therapy, physical training and occupational therapy. The physiotherapy department is equipped to provide treatment by electricity, hydrotherapy, massage, physical training, muscle development and swimming. In the gymnasium, physical training is given in classes for those who are well enough to take it. Many exercises are taken in the swimming pool.

Occupational therapy is conducted in a separate building. It consists of the lighter handicrafts, such as leather work, weaving, pottery, et cetera, and the heavier crafts, such as wood-working, automotive repairing, black-smithing, painting and machine lathe work. This work is prescribed by the doctor as part of the treatment, usually after learning from the patient his own likes and dislikes. Some of the occupational therapy is given with the object of rebuilding an injured arm or leg, teaching the patient a trade, or merely as a diversion to help him pass the time.

Another type of treatment is education. This consists of individual tuition in public school, high school and university subjects, in typing and shorthand, in book-keeping, in electrical, diesel or steam engineering, watch making, poultry raising, farming and bee-keeping; in fact, any subject which the patient may desire to take.

All education is under the supervision of paid graduate instructors. The motto at the Centre is "keep busy", as it has been found that a busy patient is happier, his morale is higher, and he recovers much more quickly than an idle one.

Recreation

The duty of the recreational officer is to furnish entertainment for the patients and to see that their spare time is fully occupied with interesting and helpful pursuits. Twice weekly the bus operated by the Centre takes a number of patients to the concerts at St. John's Canteen. Horseback riding, organized outdoor games, swimming parties and trips to outside points form part of the diversion in summer. For inside entertainment there are picture shows, dances, concerts, card games.

Counselling

As mentioned earlier, all patients are interviewed by the Supervisor of Institutional Training. This interview follows immediately after the medical examination, and during it he discusses with the patient how he can make the best use of his time, and his future prospects in the industrial world. The Supervisor gives advice, arranges courses and, finally, if the patient so desires, he makes contacts for him with prospective employers, often actually obtaining a job for him.

Auxiliary Services

Shortly after the Centre was opened an Auxiliary was organized by the ladies of Burnaby, under the leadership of Mrs. W. R. Beamish. The secretary is Mrs. A. A. Millidge. The Auxiliary is affiliated with the Central Auxiliary at Shaughnessy Hospital and is operated on similar lines. It works in close harmony with the Recreational Officer and arranges for numerous comforts, concerts, dances, and trips for the patients.

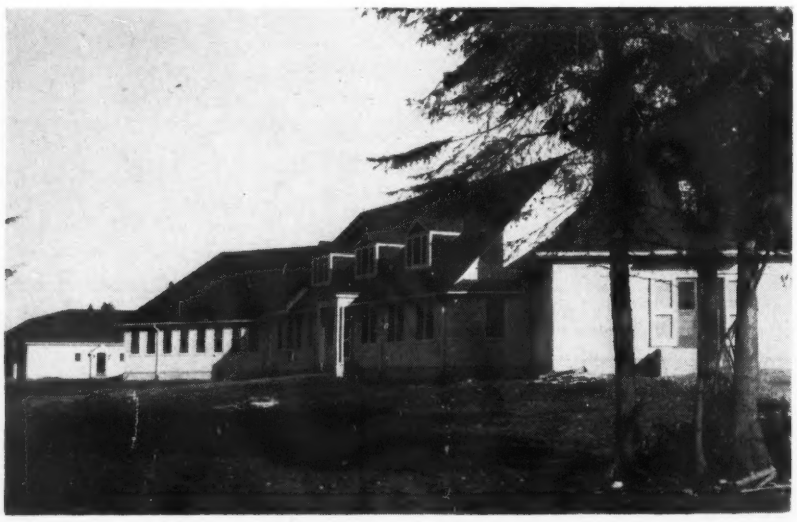
Staff

The Superintendent of the Centre is Dr. A. L. Cornish who has the over-all responsibility for the unit. He is assisted in the business management by Mr. J. C. Child, the Institutional Manager. At present there is a total staff of ninety-three.

Future Plans

The grounds and surrounding bush, 250 acres in all, are now in the process of being transformed into parklands and lawns. Projects are under way to cover the cleared area with top soil and seed it with grass, and to lay trails through the woods. When the playing field is in shape, schemes will be carried out for tennis courts, putting green, shuffle board, outdoor checkers, bowling green, miniature golf course, and other recreational facilities. Neighbouring Gun Clubs have promised assistance in the developing of a miniature outdoor rifle range.

Here at this Centre, away from hospital atmosphere and the worries and petty annoyances of business life, the patient will have a splendid opportunity to occupy his time profitably and happily during his stay; an opportunity to have good food, suitable exercises and regular hours, and to work and play himself back to health.



The Administration Building.

Illness as a Contingency of Living

[*Wherein the Patient, his Friends and Relatives, are under Mental Tension*]

Angus C. McGugan, M.D.,
Superintendent, University of Alberta Hospital, Edmonton.

WHEN one has to deal with an individual who is ill and with the friends and relatives of that person, he is dealing with a group who are under mental tension. A state of tension is not normal. It follows, therefore, that the study of the reactions of a patient and those interested in the patient is a study in abnormal psychology.

We know that illness is a contingency of living. All too frequently we attribute illness to bad luck and health to good luck. To a degree disease is preventable and health is purchasable. We accept the inevitability of the monthly grocery and rent bills. We are educated to feel the need of a home, a radio and a car. All too frequently we ignore what science has to tell us about the art of living healthfully and we make no economic provision for the contingency of illness and consequent hospitalization. Because we are the procrastinators and because we are at fault, we rationalize by attributing our inadequacy to some extrinsic source, usually the much-maligned goddess of fortune. Because we do not face the reality of disease, it follows us like a horrible phantom from the cradle to the grave. To borrow from Coleridge we are:

"Like one, that on a lonesome road
Doth walk in fear and dread,
And having once turned round, walks on,
And turns no more his head;
Because he knows a frightful fiend
Does close behind him tread."

Fear of the Unknown

Recently a friend of mine, a member of the legal profession and a man whose opinions I value very highly, was invited to a social gathering of medical men. During the course of the evening he remarked to me, "You know when you doctors get together socially you seem to be quite human, yet when I meet you in a hospital you seem to be the most aloof, awe-inspiring group of individuals imaginable. I never go into a hospital without feeling uncomfortable and apprehensive." I was somewhat surprised at this statement as he is the type of man who appears to be at ease in any environment. Probably he was equally surprised when I confided that the hours I have spent in the witness-box and in court-rooms generally are among my most unpleasant memories. To him the musty court-room, with its black-gowned judges, its trick questions and cross examinations, is as familiar a setting as the antiseptic-pervaded hospital with its white-gowned staff and medical jargon is to me. Obviously, familiarity develops understanding, and understanding is conducive to mental ease. To our patients, the hospital is an unknown factor associated with all the dread, all the fear which the unknown creates.

Conflict—Adjustment and Maladjustment

Among man's most valued possessions are his good opinion of himself and other's good opinions of him. These contribute to his self-respect or to what the psychologist calls his ego. He asserts himself or projects his ego in many satisfying channels of service and in such other ways as possession, creation, display, rivalry and mastery. As I hope to show in the course of this discussion, illness and hospitalization contribute powerfully to ego-deflation. Ego-deflation gives rise to a sense of frustration and frustration results in a mental conflict. When man finally capitulates to prolonged disease or when his life is disordered by accident, he is forced to make a tremendous adjustment, the adjustment from mental or physical ease to mental or physical disease. His ordered life is completely changed. His thinking, feeling and acting are coloured by anxiety, fear, worry and a sense of helplessness. The result is a choice between two alternatives. Our patient will either adjust by meeting the situation or by fleeing from it. We are indebted to the immortal Shakespeare for the finest picture of conflict in the English language. The gloomy Dane, Hamlet, is contemplating the alternatives, fight, or flight by suicide.

"To be or not to be; that is the question!
Whether it is nobler in the mind to suffer
The slings and arrows of outrageous fortune;
Or to take arms against a sea of troubles
And by opposing end them."

Happily for the hospital administrator the great majority of our patients adjust by facing their problems and putting up a fight. These patients and their friends and relatives make ideal hospital clientele. They are the kind of people who make hospital work a pleasure. It is a privilege to assist them in their problems. If you were to ask me for some prophylactics against fear and frustration the first and most effective which I would offer you as hospital personnel is *explanation*, rational explanation at the patient's level of comprehension. Nothing removes fear as readily as understanding. The next I would offer is *hope* —hope based on honest judgment. Finally I would offer *sympathy*, not the sloppy sympathy of sentimentality but the considered sympathy of experience. Neither the patient nor his friends can be expected to tolerate lack of interest.

Not all our patients will be so

From an address at the Western Institute for Hospital Administrators, Edmonton, 1947.

happy as to make a rapid adjustment to illness and hospital environment. There will be many maladjustments. The most common maladjustment to an unhappy or intolerable situation is regression. The present situation is distasteful, so the patient subconsciously regresses to that period in his life which was most acceptable to him. Usually childhood is the most carefree, happy period of one's life, and the patient returns to that time. What is acceptable in the child may be unacceptable in the adult. The child to himself is the centre of the universe. He is selfish, intolerant, hypercritical and demanding. When we, as administrators, meet these characteristics in our patients, and their friends and relatives, and we must expect to meet them frequently, it will help us to deal with them more intelligently if we recognize that we are dealing with abnormal mental reactions in maladjusted personalities suffering from tension.

Susceptibility to Suggestion

In their normal environments, under usual circumstances, the great majority of people are reasonable. Under emotional stress their judgments are coloured by sentiment. The sick patient is hyper-susceptible to suggestion. Obviously, every statement made in his presence should be considered carefully before it is made. The physician wants to be as sure as possible before he offers an opinion regarding diagnosis or prognosis. Anxiety over a delay in diagnosis leads the patient to conjure up all sorts of distressing ideas about the seriousness of his condition. He attempts to get inside information, even a hint, as to his diagnosis from any source—the nurse, the intern, the orderly or the visitor. His experience has taught him that those most competent to offer opinions are most reticent to do so and, conversely, those most lavish with advice and opinions are least competent to give them, but anxiety overrides judgment. The patient attaches undue significance to casual remarks and even tries to interpret his chances of recovery from the facial expressions and vocal inflections of his attendants. Attendants must be discreet if the patient is not to be misled.

Response to External Stimuli

When our patient says that his nerves are all on edge he means just that. Sense stimuli that in health are quite pleasing can be quite the reverse in illness.

The giggles and laughter of the teen-age student-nurse are music to a healthy person but irritating noise to a sick patient. The intern expressing the joy of living in a whistled tune may be torturing some pain-racked head.

The aroma of frying bacon wafted across the frosty forest air is a thing to delight the hungry hunter. The odour of frying bacon to a bilious patient is so offensive that it may readily cause nausea and vomiting.

It takes very little to please the taste-buds of a hungry boy. Almost every article on the menu is distasteful to the chronic sufferer.

Colours play some part in the therapy of our patients. Generally speaking the traditional white of hospitals irritates with its glare factor; the usual buffs and browns tend to depress. Colours towards the red end of the spectrum cheer the depressed. Quiet shades of blue and green soothe the agitated. In this province the warm colours should be found on the north and west; the cool colours on the south and east.

Certain patients will have individual preferences. These should be studied and satisfied as far as possible.

Let us consider, for a few minutes, the adjustments which the patient makes when he is told by his physician that he must go to a hospital. All his ordered routine of living collapses. All his plans and projects must be suspended or adjusted. Most of us regard ourselves as essential, if not indispensable, in our respective spheres. The mother is faced with the problem of what provision she can make for her children while she is in the hospital. For the great majority who are making a borderline economic adjustment the problem of financing their illness is a grim one. To the seriously ill, there is the consciousness of the possibility that this trip to the hospital may be the beginning of the voyage to the Great Unknown.

The patient accompanied by his anxious friends and relatives arrives at the admitting office. They have a dozen questions which they wish to ask but they find it is the admitting officer who is asking the questions. Our hospital admission form is a fairly standard one. Each question on that form is the result of considered judgment based on long and frequently bitter experience. The patient, however, does not know that it is on the basis of this form that the hospital either functions smoothly or flounders hopelessly. He does not realize that there is a rationale behind each question. Let him know that it is a standard form necessitated by administrative experience. Explain the "why" of the questions at the level of his understanding. Your patient will want to give you his own diagnosis of his condition. Don't brush away his suggestions. We all like to appear learned in fields which are unfamiliar to us. I like to hazard a diagnosis when I take my car to my mechanic. Frankly if anything is wrong with it I can gain about as much information by looking up the exhaust pipe as I can under the hood.

The first question on this admission form is, "Your name?" How much more pleasant the reception would be for the patient if the admitting officer could get a little advance information and greet him by name! We all like recognition.

The next question that is apt to cause some embarrassment is, "Your age?" I need not say that the subject of age is one about which most men and all women over nine and under ninety are somewhat reticent. Under nine and over ninety the accomplishment of years may be a subject for a little boastful comment but between those years—never! Then we have the vexed subjects of financial references, deposits and arrangements for payment. Not infrequently these are matters of worry to the patient and certainly they are vital to the very existence of the hospital. Considerate explanation as to their necessity will remove much of the resentment with which the patient meets them.

Now let us follow the patient to his bed. He is required to surrender his clothes and valuables. The surrender of these items has the same psychological effect on one's ego as the surrender of his sword had on the knight of old. The patient reaches into his club bag for the red silk pyjamas with some thought of brightening the drab hours of the nursing staff. But no! He is handed an ab-

(Concluded on page 72)

COLOUR-CONDITIONED WARDS for Australian Veterans

COLOUR is being used in a new way as a therapeutic agent at one of Australia's largest hospitals, the Repatriation General Hospital at Concord, near Sydney. It is designed to give either the effect of stimulation or stability as required by certain types of cases. Three of the prismatic colours, red, yellow and blue, were especially mixed to provide harmonious tones and varied colours in the same room.

In two of the five colour-conditioned wards completed so far, the uplift, or stimulating, theme is derived from pure yellow. Violet, the complement, has been toned down to lavender, which has a stability colour in it. These two colours have been used on opposite walls with highly glossed ceilings, white in one ward and yellow in the other.

In three other wards, colours were designed to have a stabilizing or soothing effect. In two of these, the ceilings are matt-finished white and each of the four walls is painted in a different pastel tone of the pink, lavender and yellow group.

For another ward, to be occupied by patients with ulcers or other stomach and nervous disorders, the use of stimulating colours has been avoided. The northern and southern walls are mushroom pink, the eastern wall is a warm gray, and there is a plain ochre wall at the western end.

A special shade of green, made by mixing yellow ochre, ultramarine blue and umber, to a restful milky sage green, has been used in eye-level fitments and dado walls.

The sponsors of the colour-therapy idea believe that it will not only be pleasing psychologically, but will bring physical benefit. However, it will be a year or more before they can begin to assess its therapeutic effects. The idea originated when the Federal Department of Repatriation took over the Concord Hospital from the Australian army in May, 1947. All fifty-two of its wards needed repainting and the work was begun in the standard hospital style of ivory walls and blue-green ceiling. One ward had been completed in this manner when officials became interested in a scheme developed by Mr. Augustus Aley, an architect, working as colour consultant to the Department of Works and Housing, which had the contract for the hospital's redecorating.

The reflection and direction of light were major factors in choosing colours and full use has been made of the contrast between reflective and absorbent surfaces.

Mr. Aley emphasizes the fact that this is not individual or personal colour therapy, but institutional treatment. Dealing with bed-ridden patients who have to accept the scheme whether they like it or not, means that the colours have to be just right.

Eventually, all fifty-two wards will be incorporated into the plan and, as each one is designed, new ideas are being employed. Cost of the new colour therapy treatment is only three per cent more than repainting in the ordinary way.

"Use of all medicines and drugs necessarily involves a very great psychological effect", said the superintendent of the hospital, "and that attitude towards disease is borne out by new departures. Whether we achieve any results on the disease itself by the use of colour, only time will show, but I have no hesitation in saying that . . . psychologically we are getting a result already."

Similar colour research has been started recently in Swiss tuberculosis sanatoria and in certain hospitals in Norway and Sweden.

Concord Hospital, near Sydney, where colour research is being carried out. Construction of the building was begun in June, 1940, and its first pavilion ward was occupied by Australian army patients in May, 1941. Today it houses between 1,400 and 1,500 ex-service patients, veterans of both world wars.

Condensed from an article by Mary Evans-Jones, contributed through the courtesy of the Press Attache, Office of the High Commissioner for the Commonwealth of Australia, Ottawa.

The Vocation of the NURSE ASSISTANT

Sister Beatrice, S.S.J.D.,
Administrator,
St. John's Convalescent Hospital,
Newtonbrook, Ontario.

IN the matter of personnel for nursing care we are as observers on a hilltop who, gazing below, are concerned how best to cope with the parched fields that meet the eye. Now, experts in conservation tell us that a hillside, to be fruitful, must be ploughed horizontally, in curved furrows. In seeking to meet the situation of nurse shortage, we may have to bend our ideas and not hold rigidly to the vertical lines of our thinking heretofore. There is only one place that necessitates rigidity, and that is where principle is involved, principle itself not being confused with prejudice or custom.

In the earlier days of training schools the superintendent of nurses had, perchance, three or four assistants. Otherwise, all the nursing was done by "student", or as they were then called, "pupil" nurses. A senior was made a head nurse in her second year (two years being the length of training), and she was distinguished outwardly by a black band on her cap. The candidate was accepted for probation on the basis of a personal interview. These young women were entrusted with all the practical work in the care of the patients; this included various treatments, dressings, et cetera, and trained vigilance in the observation and charting of symptoms.

Our deduction from that fact is that young women who have been carefully selected for auxiliary work should be equal to taking a considerable amount of responsibility, and able to release the graduate nurse for administration, special treatments and supervision.

Now, what is to be the standard for women entering the training school for nurse assistants? At the present time, the government is having these young women trained especially for work in hospitals. Therefore, my thoughts are given from that standpoint. Would it not be politic to designate them Certificated Hospital Nurse (C.H.N.) or Hospital Nurse Licentiate (H.N.L.)? Indeed, as a matter of fact, the *graduate* nurse of today with her capability and highly trained technique might well be called a Registered Medical Technician.

One regrets that the educational standard for entrance to the course for nursing assistants has been lowered from two years of high school to entrance standing. How does a young girl spend her time between the ages of 14 and 18, before she may begin training? Think you it has been in such manner as would fit her for nursing?

The woman whose duty and privilege it is to relieve suffering and administer the elixir of health needs to combine the consciousness of vocation with intelligent training. It is from the graduate nurse that the nurse assistant will take her tone. She must see in her that spirit of selfless service which characterizes all those who put the patient first.

On the other hand, one feels that wide latitude should be allowed the Registrar if the standard were set at two years of high school *or its equivalent.* Our experience has proved that the "equivalent" may be that of the housewife who has spent a few years or many in caring for others, providing for others, thinking for and of others—a most excellent foundation upon which to build the technique of nursing! Or again, it may be one who has had experience in office work, where she is trained to value system, accuracy, courtesy, reference and deference to authority, et cetera—another good foundation. The candidate may have had a business course and gained experience in public relationship. So, with latitude and discretion, wise selection may be made.

The formative years of this departure will colour the future. The patient and the visiting public will have much influence in creating this supply; they will foster or condemn it on its merits. It is the young woman with a vocation, the "born nurse" if you prefer—it is she whom we would seek to train. Training there must be, and this should be given first and foremost from the standpoint of the patient. Ministry to the sick must be exercised intelligently.

There should be laid a strong foundation of practical psychology; not that the candidate may sit down and write an examination incorporating technical terms, but that she may be directed to seek the patient's point of view, soothing a restless body and relieving an anxious mind, and studying to do all that will set the patient at rest. She should learn to control her voice and inflection, to move quietly, place the pillows comfortably, see that the light is not too disturbing, that the bell and water jug are within reach, and she should exercise great care for personal belongings and flowers, and the dozen and one other things that she, who can put herself in the patient's place, will know how to do. Furthermore, it is imperative that the candidate be given a sound ethical training. It is there that we are most apt to run into difficulties in employing the untrained practical nurse. She must be taught the sacredness of a patient's confidence and the honour which requires silence on all matters that come to her in the performance of her duty. She must also be taught to appreciate the privileges and responsibilities of group membership.

I had the privilege recently of visiting the training centre for nurse assistants in Toronto, and I feel that great credit is due those who are endeavouring to formulate and estab-

From a paper presented at the O.H.A. Convention, Toronto, 1947.

Candle Lighting Ceremony for "Class of 1950"

FIFTY-TWO student nurses, the largest class yet to enter the Toronto East General and Orthopaedic Hospital School for Nurses, were formally received into the training school on Tuesday, March 9th, after having successfully completed a five months' probation period.

The candle lighting ceremony was conducted in the classroom of the nurses' residence before an audience of almost three hundred guests. Relatives and friends, as well as members of the hospital executive and staff, watched the superintendent of nurses personally place on each girl her cap, the symbol of her entrance into training for her chosen profession.

Congratulations of the board of governors were conveyed by Mr. J. E. McMillin, chairman of the training school committee, and Mr. W. E. Leonard, superintendent of the hospital. Miss Pearl Bailey, first-ranking student of her class, extended to the hospital and training school the thanks of her classmates, and expressed their avowal to live up to the ideals of their profession and their school.

The service was brought to a close with the benediction, offered by the Reverend T. W. Barnett.

The afternoon, a momentous one in the lives of these young women, was concluded with tea in the the hospital dining room.

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lish the course. It was interesting to find that practical training in the *domestic work of the hospital* is included. The trainees are responsible for the cleaning and dusting of their classrooms, the utility rooms, diet kitchen, nursery, et cetera. The green uniform, covered with a specially designed white smock and a cap faced with green is distinctive. Now, if this group is to consider itself an integral part of the hospital, the members must have their organized conferences and be given such information as will make them realize that they are a part of the whole, woven into its fabric. They should visit the laundry, the linen repair and replacement departments, also the food source, i.e. kitchens and refrigerators. The more they can see of the inside working of the institution, the more will be their interest and co-operation in the intelligent carrying out of their duties.

Summary

While it has been found necessary to accept such a low entrance standard as now prevails in Ontario in order to meet an emergency, one feels that there should be a long range view aimed at something higher, making the ultimate objective a group of capable bedside nurses with a solid foundation of practical psychology and ethics, and in whom the consciousness of "belonging" will develop a spirit of *esprit de corps* and of loyalty towards their hospital. To attain this the educational standard must be raised, and latitude in selection be allowed those responsible for deciding upon what experience is "equivalent".

We shall be successful in this auxiliary training only in proportion as we combine efficiency and personal service. It was said to me by one of the officers of the course: "The graduate nurse will either make it or break it". That is a great challenge!

It is a new sprout; we must watch it and tend it, lest we have a weed growth. It must be cultivated wisely, not with restriction as the dominant note, but with the purpose of developing and expanding its usefulness.

B.C. Association Issues Bulletin

It has been announced by the secretary of the British Columbia Hospitals' Association that quarterly bulletins are now being issued to the members. A copy of the first issue indicates that it will be very helpful in keeping members informed on latest developments in the field.

How to Reduce Hospital Printing Costs

George E. Masters,
Assistant Superintendent,
Vancouver General Hospital.

THE cost of printed forms is increasing in all of our hospitals because of the continual introduction of new ones. If this cost is to be reduced a systematic control is necessary, and control must be based on a knowledge of the principles and methods of form design.

Office work may be divided into three general classifications: (1) writing and interviewing; (2) computing; (3) classifying and filing. Paper work is required in all of these operations.

Paper is the raw material used by the hospital clerks and we are now in an era when the clerks are in danger of being smothered by the volume of paper work they are handling. This is a matter which needs to be attacked through a concerted effort or we shall be swamped and forms will have won the paper war.

A survey of the cost of printed forms in hospitals will reveal that the annual cost is as high as $200.00 per clerk. With proper care and attention, you will find that savings from 30 to 50 per cent are not uncommon. The value of the savings will be in direct ratio to the amount of time and effort expended on control. Do not permit anyone in the hospital to order a new form until it has the full approval of the person in charge of forms.

The first step in control is to establish a separate expense account for printing costs, as distinct from office supplies and stationery. Only thus can you evaluate the results of your system.

It is especially important that a *trained* person be in charge of all printed forms or, if it can be conveniently arranged, it is even better that you appoint a *forms committee* so that new designs will have more assurance of meeting the requirements of both medical and clerical departments. This committee might well include the nursing supervisor, the office manager, record librarian, and the purchasing agent.

The final step in such a system is the adoption of a standard specification form which requires the designer to present a standard list of details concerning any new form, including such details as general description and purpose of the form, how it is to be used, whether it is to be ruled, padded, punched, the normal consumption, grade of paper for each copy, colours of the copies, checked by, examined by, et cetera.

Your clerks will be amazed to learn the amount of detail you wish to know about their new forms, and when they have completed this detail they will have performed a quite thorough checking job on their own brain children. You will, in this way, avoid having to inspect quite a number of new forms which would not progress past the embryo stage.

Principles of Form Design

Points to be considered in designing printed forms or in re-designing those at present in use in the hospital are: purpose, size, simplicity, facility of use, layout (or make-up).

1. *Purpose of the Form.* Be sure that the form will accomplish the purpose for which it is being designed. Sometimes we find that much of the information to be provided is readily available on another form which must be prepared even though the new form is adopted. We are more often guilty of duplication than of not producing sufficient information; but in either case the error is similar, the *one form* does not accomplish the utmost in end results.

2. *Size of the Form.* A new form should be of the minimum *standard* size which is readable, with due consideration given to convenience in handling and final disposal of it.

In our hospital recently a clerk re-designed a form, which had been giving us a considerable amount of trouble, and in doing so she had added three-quarters of an inch to the depth of the sheet. The majority of the changes were readily agreed to but upon close investigation I realized that the change would require $400.00 worth of new filing equipment because of the added depth.

Again, it is costly in labour to design a form which requires two folds to slip into an envelope if one fold will do.

3. *Simplicity of Design.* Headings should be *brief* but should contain sufficient description in concise and clear wording as to leave no doubt regarding the purpose of the form. Make every effort to avoid using complex medical nomenclature in your forms as clerical staffs are now required to absorb more of the paper work and these terms are unnecessarily baffling to the neophytes in our offices.

Numbering of forms is necessary for stock-keeping purposes but it is my advice that you refer to your forms by name and standardize on these names. Train your employees to refer to forms by name, i.e., refer to a laboratory report as such and not as M96. Simplicity always pays by avoiding confusion.

Do not put cryptic, puzzling, heads on the columns or in the question section of your forms. Abbreviations lose their value if they become puzzles.

4. *Facility of Use.* Lay out your forms so that they are easy to use. Give particular attention to the sequence of information to be filled in with a view to ensuring that the information follows in logical order and use the same sequence on the several forms where information is necessarily duplicated.

There are three main reasons for standardizing your sequence of information: to lessen the errors of omission on the part of employees; to facilitate transcription: to permit the duplication of several forms by means of duplicating machines.

Make all questions clear and put the lead as a question, if at all possible.

For example: Do not use—No. ordered; use—How many ordered? *No. Ordered* and *Order No.* can so easily be confused.

Information should be so placed

on a form that it will best fit the purpose of the form. This is elementary but it is a first principle. For example: If your form is a card to be filed alphabetically, the name should appear at the top. If the name is one inch below the top, the value is lost.

5. *"Make-up" of Forms.* It is standard practice for forms to be divided into three parts:

(a) Identification Matter: This section gives the patient's name, address, hospital number, doctor's name, et cetera.

(b) Data on Main Section: This includes the information relative to doctor's orders and diagnostic services.

(c) Instruction: This section is reserved for items of secondary importance such as authorizations, signatures for receipt, or even instructions on the use of the form itself.

The appearance of your forms is essential to the morale of the clerical staff. Be consistent in your form design so that your employees will recognize one of your forms as soon as they see it.

It is not necessary to launch into a thesis on type and general form dressing as this is a job for the specialist, but do not use Old English headings on some of your forms and Gothic on others. Standardize on using the full name of your hospital on all forms and avoid using just the initials.

Forms for typewriter use should not have ruled lines as this usually requires a second adjustment after the form is in the machine. Indicate the first line clearly with a broad arrow or extra heavy line to save time for your typists. Standard typewriter spacing is six to the inch.

Avoid coloured lines as this is an expensive printing job and you can achieve the same results by varying the width of your rulings.

Method of Designing Forms

There is a definite system to be followed in constructing a new printed form and if you will follow this sequence and keep in mind the *principles of form design* as outlined above, you will be able to avoid any major problems.

1. *Analyse the Purpose of the Form*

Before you commence work on the new form, give due consideration to its purpose by studying some of the following points:

(a) If more than one purpose—which is primary?

(b) Is the purpose justifiable?

(c) Will the purpose be fully accomplished by the form which you are considering?

(d) Is there another form for a similar purpose now in use in the hospital?

This is a point at which you will either abandon the new form or combine some additional information in a present form or discard a form now in use by the introduction of a new one or, lastly, add one more form for use in your hospital.

2. *Use of the New Form*

When you have decided that it is necessary to replace one of your present forms or add another form to your routine, you must next con-

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AWARDS Announced *for 1947 Articles in* "The Canadian Hospital"

THE Editorial Board and Executive Committee of the Canadian Hospital Council have announced the prize winners for articles appearing in *The Canadian Hospital* during the year 1947.

The first prize ($100.00) has been awarded to Mr. F. B. Walker, Engineer, Ottawa Civic Hospital, for his instructive and very polished article, "The Superintendent Meets the Engineer". The second prize ($50.00) goes to Mr. Percy Ward of Vancouver for his practical and beautifully phrased discourse on "Economic Aspects of Hospital Administration". These articles both involved wide knowledge of the subjects under discussion and the ability to make concrete suggestions in a smooth and pleasant prose style. Mr. Walker's article was written *for* the journal, required practically no editing, and illustrations were supplied by the writer.

While the above awards represent the final decision of the judges, it was not at all easy to choose from among the many excellent articles published throughout the year. The great variety of subjects, and the fact that subject matter itself does, to some extent, dictate the style and possible illustration of an article, makes comparison difficult in many cases. Several articles received almost equal rating when marked in accordance with the standing criteria. In making their decision, the judges took into consideration the amount of editing and re-arrangement which manuscripts required before publication. They also noted favourably those articles which were written specially for *The Canadian Hospital*, though this was not by any means one of the most important factors.

Special Merit

Among those articles which were considered to be of outstanding merit, the following have been given honourable mention: Budget Control for the Small Hospital, by George Masters; We Look at Nursing Service, by Sister Catherine Gerard; Tranquille Farm, by Paula Reber, Margaret Leith and Pearl Caswell; Hopeful Aspects in the Fight Against Cancer, by G. E. Richards, M.D.; Employer - Employee Relationships, by Nellie Gorgas; How Sound Are Your Purchasing Methods? by Donald Cox; How to Cope With Dietitian Shortage, by Sister Irene Marie; Psychological Principles in Hospital Administration, by A. C. McGugan, M.D.; A Hospital Engineer Looks at His Job, by N. McLeod; Better Hospital Facilities for Rural Patients, G. L. Davis; Are You Planning to Build? by Prof. Eric Arthur; Hospital Requirements as Dictated by Modern Trends, J. C. MacKenzie, M.D.; How Emergencies are Handled in a Large Metropolitan Hospital, by W. R. Slatkoff, M.D.; How Clean are Your Dishes? by Jean Hall; A Sanatorium Celebrates Christmas, by A. L. Paine, M.D.

Hospitals Being Forced to Increase Rates Again

As hospital news from all parts of Canada is scanned, that vexing bogey "rising costs" appears in bigger and blacker headlines from week to week. The increase in costs is attributed everywhere to the augmented prices of materials and supplies, and to higher wages. It is all in line with the rapidly increasing cost-of-living in general and during recent months has led to alarming hospital deficits. The obvious result is that hospitals must again raise their rates to the paying public and/or receive further municipal and governmental assistance, if they are to continue in operation. We quote from a number of news items which have appeared recently in the public press.

VICTORIA, B.C.: At the beginning of the year rates at the Royal Jubilee Hospital were raised by an average of $2.00 a day. Charges under the new schedule are: Wards, $6.50 a day; semi-private rooms $7.50; and private rooms $9.00, $10.00 and $11.00 a day. Rates for maternity cases, i.e., mother and baby, are: Ward, $8.50; semi-private $9.50; and private $12.50. When the baby is kept in hospital, the rate is $2.50 per day. Children's ward rate is now $6.00 per day.

POWELL RIVER, B.C.: The board of governors of Powell River General Hospital announced an increase in rates of $1.50 per day effective February 1st. This brings ward rates up to $6.50 per day while semi-private patients will be required to pay $7.50.

KELOWNA, B.C.: Last month the board of directors of the Kelowna Hospital Society, faced with a deficit of $20,000, raised room rates by 50 cents a day. Public ward rates are now $5.00 a day. At this 85-bed hospital, salaries alone accounted for an expenditure of $24,000 more in 1947 than in 1946, amounting to $100,000 for the past year.

CALGARY, Alta.: The Calgary General Hospital suffered an operating loss of $152,000 last year. "To maintain an adult patient in the hospital for a day costs $6.00 . . . yet the

hospital charges a resident patient only $2.50 per day for ward care and a non-resident $3.75." Semi-private accommodation costs the resident patient $3.50 per day and the non-resident $4.75, while private room charges are the same for both, ranging from $6.00 to $6.50.

EDMONTON, Alta.: City will likely have to contribute $40,000 more in 1948 than last year in grants to the Royal Alexandra Hospital. This will bring the required contribution from the city up to approximately $120,000.

MEDICINE HAT, Alta.: Robert Calder, chairman of the board of Medicine Hat General Hospital, said: "Speaking personally, our rates are as high as they can go. . . . If you raise rates too high, all you accumulate is debt". The board has appealed for an increased municipal grant to meet mounting deficits.

REGINA, Sask.: The annual report of the Regina General Hospital revealed a cost increase of 85 cents per day in 1947 over the 1946 figure. As of early this year, the actual cost to the hospital was estimated at $6.04 per patient day.

WINNIPEG, Man.: "The rates are as high as we can put them now," said Dr. H. Coppinger, superintendent of the Winnipeg General Hospital, "and we can't add anything more." He also pointed out that for public ward patients the municipality was paying $2.00 per patient day and the Government 50 cents per day, whereas the cost to the hospital is $5.00 per patient day.

LONDON, Ont.: Room rates at Victoria Hospital were raised by 50 cents a day in January to help offset wage increases totalling $60,000. The charges for private rooms now range from $6.00 to $8.50, semi-private accommodation costs the patient $5.00 or $6.00, and the ward rate is $4.00 per day.

OTTAWA, Ont.: Controller Dr. G. M. Geldert said a few weeks ago that unless the Ontario Government provides immediate relief the trustees of the Ottawa Civic Hospital will have to ask the city for an additional $250,000 this year or curtail its operations. He pointed out that while the average cost to the hospital per patient day is $7.00, the Government allows the city to charge indigents from outside the municipality $2.25 a day and then adds a grant, "the munificent sum of 75 cents a day and the city taxpayer pays the balance".

SARNIA, Ont.: In February the Sarnia Hospital Commission approved higher rates to patients. Rooms formerly priced at $4.50 now cost the patient $5.50 and others have been raised from $5.50 to $6.50. Miss R. Beamish, superintendent, pointed out that the actual per diem cost to the hospital in 1947 was $8.00 and is now substantially higher.

TORONTO. In March three hospitals, the Toronto General, St. Joseph's, and Riverdale Isolation Hospital, raised their rates to patients. The Toronto General lifted its ward rate from $4.00 to $4.50, semi-private from $6.25 to $8.00. Private rooms run from $9.00 to $12.00 a day. At St. Joseph's, private rooms now cost $7.00, $8.00 and $9.00. The new rates at the Isolation Hospital are $7.00 for semi-public wards, $9.00 for semi-private and $11.00 for private rooms. The average cost per patient day to the hospital is $7.00 in this city.

A deputation representing the Toronto General Hospital conferred with the city Board of Control last month and asked that the city assume responsibility for a deficit of $349,000, which amount is said to be but the city's share of the deficit for care of indigent patients. "If the hospital doesn't get this money, it will have to close up," said Alderman Lamport, adding "It's down to the bottom of the barrel now."

MONTREAL, P.Q.: A spokesman for the Montreal Hospital Council has expressed the opinion that all hospitals in that city will show increasingly high deficits for the current year "despite the seemingly high rates charged to the public". The solution indicated is an "appeal for larger grants than ever requested in the history of Montreal", as well as still higher charges to patients.

SHERBROOKE, P.Q.: The board of governors of Sherbrooke Hospital have sanctioned two increases in charges to patients within the past few months. The rates now stand at $3.50 for public ward accommodation, $5.00 and $5.50 for semi-private, and $6.00 and $7.00 for private rooms.

SAINT JOHN, N.B.: The board of governors of Saint John General Hospital recently authorized an increase of 50 cents per day in charges for private and semi-private rooms, and 75 cents per day for ward accommodation. The new rates are $6.00, $6.50 and $8.00 for private rooms; $3.50, $4.00, $4.50 for semi-private; and $3.00 for wards. An additional $1.00 per day is charged to non-resident private and semi-private patients and $1.50 extra to ward patients from outside the city. Charges for various "extras", including operating room fees, have also been increased.

School for Nurse Aides Established in Montreal

A school for the training of nurse aides or assistants is now being conducted at the Montreal Convalescent Hospital, under the auspices of that hospital and also the Herbert Reddy Memorial, the Homoeopathic, Jewish General, Montreal General and St. Mary's hospitals.

The course is designed to cover a period of six months instruction and supervised practice in the care of non-acutely ill, chronically ill and convalescent patients, followed by another six months of supervised practice, on salary, in one of the above hospitals. Upon successful completion of the course students will receive certificates. The curriculum has been approved by the Association of Nurses of the Province of Quebec and by the Montreal Hospital Council.

The Board of Trustees of the new school have announced the appointment of Mrs. Lawrence Fisher, a graduate of the University of McGill School of Nursing, as director. Applications are now being accepted and further information may be obtained by writing to the director at the Montreal Convalescent Hospital, 3001 Kent Avenue, Montreal.

Obiter Dicta

Mental Care Publicity

IN recent years there have been several splurges of publicity attacking our mental institutions and causing grave anxiety to the relatives of patients receiving treatment. The fact that the attacks on the well-administered hospital at London came to nought, despite an appraisal of the doctors' diagnoses and treatment by orderlies before a Commission of "experts", received much less publicity than the original criticisms. And most people will remember the violent attacks on the mental hospital at Fairville, N.B., but probably failed to notice that a careful investigation found little indeed to criticize. More recently, an individual has seen fit, in a public address, to accuse mental hospital attendants in Ontario of cruelty to patients, ranging from petty irritations to manslaughter.

We suppose writers must eat and are well aware that criticism, especially if not toned down by substantiated facts, finds a ready response. It is timely that Dr. Clarence M. Hincks, general director of the National Committee for Mental Hygiene, should issue a really constructive and helpful statement on mental care today. (See page 52.)

In contrast to emotional criticism of doubtful value, we note a very reassuring five-volumn spread by Cory Kilvert in the Winnipeg Free Press (March 10) reporting a "9-Hour Tour of Mental Hospital" by a party of Manitoba legislators and press representatives who visited the mental hospital at Brandon. This visit was probably the result of an attack on the mental hospitals in Manitoba by the C.C.F. member for Assiniboia. "Main impressions taken away by the visiting party were:

> **Amazement at results of modern curative treatment on mental patients;**
> **Admiration for the work being carried out by doctors, nurses and attendants."**

Further: "Party finds overcrowding, but patients well cared for. . . . Although the atmosphere is depressing to the visitor, there is no feeling that this is a place where sadist attendants ill-treat their less fortunate fellow men and women." In the nine hours the group covered the entire plant, inspecting kitchens, occupational therapy rooms, the workshops and locked solitary rooms. "Except for a general agreement among visitors that 'chronic' wards in the main hospital building were overcrowded, and hallways there were dark compared to the modern, bright reception building, little criticism was voiced." This would seem to be a fair appraisal. Again we have evidence of the fine spirit of constructive co-operation between the professions, the hospitals, the health department and the press, so obvious in Manitoba.

Hospitals Disapprove W.C.B. Action

HOSPITALS in Ontario are very much concerned about the proposed coverage by the Workmen's Compensation Board of hospital personnel against the hazard of tuberculosis. For two years hospital employees have been covered by the Workmen's Compensation Board against ordinary hazards of employment and last year recommendation was brought down to add tuberculosis coverage. The initial rate for employees against ordinary hazards was 30 cents per $100.00 of payroll. Last year this was raised to 50 cents and the Board have intimated that if tuberculosis coverage is added, a tentative rate of $1.50 per $100.00 of payroll would be assessed. Under ordinary coverage the hospitals have been assessed for pupil nurses at the rate of $30.00 per month, which is the normal allowance for maintenance. Under the new tuberculosis coverage the hos-

pitals would be assessed for the maintenance of pupil nurses at the rate of $75.00 per month and for interns at the rate of $100.00 per month. The Board have further stated that from their statistics the cost for this coverage should be 50 cents for ordinary coverage plus $1.63 for tuberculosis, or $2.13 in all.

The public is now very tuberculosis-conscious and in that province much publicity has been given to the hazards faced by the student nurse; actually the dangers have been greatly exaggerated. This forced inclusion of tuberculosis by the W.C.B. would seem to be related to this public agitation. The logic seems a bit confused, however. Hospitals would be required to pay for the care of tuberculous engineers, cooks, repair men and others who never come in contact with patients. No other industry is asked to include such cases as occupational hazards. Moreover, the plan, while including those not in contact with patients, does not cover private duty nurses, the doctors, school girls and other part time workers, medical students, nor the social service group. The hospitals should not be responsible for the financing of tuberculosis in those groups of employees where its occurrence is not an occupational hazard. Rates are said to be based upon known cases among hospital personnel, but in the case of many of them there can be little evidence, and no proof, that the condition was the result of infection in the hospital. The hospitals have not been assured that cases among private duty nurses, for which the hospitals have no responsibility, have not been included.

The increased assessment for this coverage would present a very acute problem to the hospitals of the Province, as from the payroll figures for the year 1948 it would seem in the neighbourhood of an increased assessment of $200,000.00 which the hospitals would have to find. In Toronto alone, the assessment would be increased from $34,000.00 to $119,000.00. The Compensation Committee of the Ontario Hospital Association takes the viewpoint that this money could be much better expended in financing routine x-ray examinations of patients. Actually tuberculosis is dropping rapidly in that province as in other parts of Canada. In 1936 the mortality was 36 per 100,000 and by 1946 it was down to 25.8 per 100,000.

Committee Reports Against Australian Cancer Treatment

ANOTHER hope for sufferers from cancer has gone the way of a long list of "cures" which have been given wide publicity from time to time. In recent months a treatment developed by a John Braund in New South Wales has attracted much attention and already two or more women in Western Canada have flown to Australia at considerable expense.

On March 9th a cable from the New South Wales Government was read in the Canadian House of Commons stating that a committee of experts was now investigating the treatment and strongly recommending that patients do not go to Australia for treatment. On March 26th this committee, under the chairmanship of Dr. Morris, reported that Mr. Braund had not submitted satisfactory evidence that he can cure cancer. Apparently twelve of the patients were to have been examined, but it was stated that only six submitted to an examination by the medical board.

Staff Co-operation on Emergency Admissions

TO-DAY with bed space at a premium, hospitals everywhere are advising their medical staffs that accommodation must be limited to those urgently in need of hospital care. And the vast majority of staff doctors would seem to be giving full co-operation in meeting this very trying situation. Apparently there are some, however, who, to put it mildly, are so concerned with the welfare of their personal patients, even though not seriously ill, that they fail to consider the interests of other patients in the community. Every now and then we hear of staff members who rush in emergency tonsillectomies, emergency perineorrhaphies and suspensions, and even emergency checkups. What can be done to prevent such abuses?

If at all possible it should be left to the medical staff to deal with these offenders. Opinion may differ as to when an emergency exists and the medical opinion of one or more appointees of the staff would be necessary to safeguard the hospital should the patient not do well following refusal of admission or early discharge. Rules should be drawn up by the medical staff and, if necessary, a screening committee named. Repeated and obvious misuse of the term "emergency" would well warrant the offender being brought before his colleagues to show reasons why he should not be suspended from the staff. In most instances, we believe, the chairman of the staff can correct the situation by a personal conversation.

It has occurred, however, that one or more staff members have ignored the requests of the hospital management and the advice and warnings of their colleagues who have played the game. Our advice in such matters has been that the staff appoint a committee to check all emergency admissions and final diagnoses and ascertain which of them really were emergencies. If, after considering all factors, it is found that certain staff members are obviously abusing their privilege, these men should be bluntly told that the staff means business. Either of two courses of action could be taken. All requests for emergency admission could be screened by a staff committee. If the staff does not desire to undertake this, a quota system could be set up. This might need to be on an equal basis, for to set a quota on a basis of previous admissions would favour those who had been following unfair practice. Each doctor would then fill his quota of beds as he would see fit. Of course, a certain number of beds should be kept outside of the quota to provide for *bona fide* emergencies, sent in by any member of the staff. Here, too, some abuse might take place, but at least the other doctors would have some beds for their acutely ill patients.

Futher Correspondence on

Radio Interference

FURTHER correspondence respecting the control measures of the Federal Government to prevent interference with radio communications by electro-therapeutic equipment has taken place between the Canadian Hospital Council and the Federal Government.

Honourable Lionel Chevrier,
Minister of Transport,
Ottawa.

Dear Mr. Chevrier:

Re: Restrictions on Use of Electro-therapeutic Equipment

At its recent meeting the Executive Committee of the Canadian Hospital Council again strongly protested the restrictions effective January 1st on the use of electro-therapeutic equipment.

The hospitals object very strongly to being required to scrap valuable equipment and to purchase new equipment at a high cost at a time when hospital costs are already beyond the ability of the patients to pay, and at a time when much research is being done towards the development of newer equipment. The United States regulations giving hospitals five years in which to make the change-over is permitting them to take advantage of an extensive amount of research that may well evolve equipment that will render obsolete apparatus available today. To place Canadian hospitals under restrictions not applicable to the hospitals of the United States is unfair and may well result in the loss of tens of thousands of dollars to our public hospitals, all of which are operating on a non-profit basis.

The hospitals do not feel that they should be required to make these changes when American hospitals just across the border can continue to emanate the disturbances which hospital apparatus is said to create.

Moreover, despite statements that supplies of equipment are available, hospitals are reporting that orders placed for the equipment selected are not being filled.

That notice of these regulations was given some time ago is recognized, but the hospitals cannot be held responsible for the fact that development of apparatus during the war years was not carried on by manufacturers, nor is it the responsibility of the hospitals that some of the firms doing very extensive research on electro-therapeutic equipment have not as yet marketed the results of their research.

On behalf of the hospitals of Canada it is again requested that a further extension of time, comparable to that prevailing in the United States, be given to Canadian users of electro-therapeutic equipment.

Yours respectfully,

"Harvey Agnew"
Executive Secretary,
Canadian Hospital Council.

From Controller of Radio

As radio control now comes under the Department of Reconstruction and Supply, the above letter was referred to the Minister of Reconstruction and Supply. The reply received from that Department is as follows:

Dear Dr. Agnew:

I am directed by The Right Honourable the Minister to reply to your letter of the 3rd instant addressed to The Honourable the Minister of Transport.

Each of the points referred to in your letter has been given very careful consideration by the officials of the Department, representatives of the Canadian Medical Association, and manufacturers, at meetings of committees of the Canadian Standards Association.

Realizing that there is so much involved in the control of radio interference from the use of diathermy equipment, I am pleased to deal with each point in detail. When the broad view of the situation is understood, I feel sure that the Executive Committee of the Canadian Hospital Council will realize the necessity for immediate control.

Many hospitals and institutions are providing shielding for their therapeutic treatment booths in which to use their present equipment, and are purchasing the new type of frequency stabilized diathermy units, for portable use.

Many manufacturers have not only been carrying on research on frequency stabilized units for a number of years, but some types of stabilized units have been in operation in the United States Army and Navy for at least four years.

We can see no reason why the change in the design of the equipment required to stabilize the frequency should in any way affect the therapeutic value of the treatment. Apparatus of this type, which embodies the principles so thoroughly tested for many years, will surely not soon become obsolete.

The costs involved in supressing radiation from electro-therapeutic equipment are fully realized, but the total sum required throughout Canada in this respect is small compared with the amount the radio industry is spending to overcome interference. Many committees of the Canadian Standards Association, the Canadian Radio Technical Planning Board and other organizations have for years been endeavouring to find a solution which will be equitable for all concerned.

The difference between radio reception conditions in Canada and those existing in most parts of the United States was explained in our letter of November 19th, 1947, in the following terms:

"Radio reception conditions in Canada differ considerably from those in United States, particularly in respect to the natural static level and the great distances to be covered in a country so sparsely populated as ours. Because of these conditions, it is not only possible, but also economically necessary that communications be carried on with transmitters of lower power than are commonly used in the United States, and it follows that much more rigorous control of interference will have to be maintained in this country. These reasons have indicated the policy of enforcing the necessary suppressive measures immediately, and further five-year extension of time would delay a proper development of higher frequency services which are essential to the economic and industrial advancement we all desire."

The Department has made provision for hospitals and practitioners to continue to use their present electro-therapeutic equipment in all cases where material or equipment required to prevent radiation has been ordered and cannot be supplied immediately, as explained in our previous letter, as follows:

"Our District Superintendents of Radio have been notified that they may issue written authority for the use of present equipment until it can be replaced or suppressed, provided that no essential services are interfered with, and that a reasonable effort is made to expedite the change-over."

We trust that you will appreciate the necessity for the closest co-operation of all users of radio frequency energy, as this is the only means whereby our country can derive full benefit from the latest advances in the application of high frequency technique to both the radio art and medical practice.

Yours very truly,

"G. C. W. Browne"
Controller of Radio.

"Come in and Get Acquainted" on

National Hospital Day

FOR the past twenty-seven years, May 12th, the birthday of Florence Nightingale, has been set aside by hospitals as one special day in the year to be devoted to public education. By concerted hospitality and concentrated publicity on this day, hospital officers have each year made great strides in the matter of happy public relations. All activities planned for May 12th should be directed toward the common purpose—"that the community may know its hospitals". It is the day of all others when every opportunity should be given the public to learn of the hospital's varied services, its plans for expansion, and its needs.

It is easier, quite naturally, to arouse enthusiasm in smaller centres but if a common effort is made by all hospitals, National Hospital Day can be, and repeatedly has been, a great success in our largest cities. The only difference is that in the second case emphasis must be placed upon publicity of a general nature rather than upon personal contact with individuals. The various media are known to all and in this day of health consciousness, it takes little persuasion to get a "plug" for a good cause in radio programs or on the screen. Send releases to your local papers and suggest editorial comment upon your deeds and your needs. Posters should be prepared well in advance and appear in store windows, street cars, and on bill boards. Have announcements made at all local churches, lodges and clubs, telling of your services and your aspirations. Delineate your program for the day itself in every possible public place.

It has long been customary to hold "open house" on May 12th and there is no better means of arousing public interest in the service you are giving. What people see they believe. Organize tours and allow observers to inspect not only wards but service departments, in as far as this is possible without disrupting regular hospital care.

The dietary department is always a sphere of special interest to homemakers, and visitors enjoy looking at babies—even through a glass wall. Also, by way of demonstration, it might be feasible to take a few free photofluoroscopic x-rays.

In this day of nurse shortage, such a public reception is an opportunity to suggest nursing as a career to younger visitors and their mothers; to show that nurses are comfortably housed and work under conditions which are above criticism.

Members of the Board of Governors and their wives should be honoured guests as well as the medical staff and their families. It is well to have among those receiving and entertaining visitors, as many as possible of the regular staff—the superintendent, of course, supervisors, nurses and technicians. Meet the public in your off duty clothes and let them know that you are friendly, hard-working people—not just so many pieces of starched efficiency.

Besides the regular staff, almost if not every hospital has at hand an ever-ready group of assistants for such an occasion—the members of the hospital auxiliary. These ladies will, in the weeks before, solicit advertising in every form, make practical suggestions for a program on May 12th and help to carry it out with êclat.

Incidentally, it is a good idea to keep a guest book for this day. It is a tangible record of those who are definitely interested in your hospital.

National Hospital Day is a culmination, a high point, for the hospital's year-round public relations program. Put on your best bib and tucker, a welcoming smile, and prepare to prove that your hospital is a place of kindly, sympathetic and helpful service. —*J.F.*

The brown earth is stretching and ready to rise—
With flowers in her bonnet and tears in her eyes.
Children are playing with marbles and ropes,
While the first blossoms smile on warm sunny slopes.

—From "Springtime" by Margaret Rhynas.

Graphic Hospital Story Depicted by Magazine

By way of publicity and in an attempt to improve and extend public understanding of hospitals and their work, a special photographic story about hospitals has been published in the April issue of *Coronet* magazine. Articles of this type in current magazines should do much to help accomplish more wide-spread support for and interest in hospitals. Reprints may be obtaine dfrom Readers' Service, Coronet Magazine, Coronet Building, Chicago, Illinois.

Alberta Experience with Routine Admission X-rays

THE first report of experience with routine radiological examination on hospital admission has been made public by the Alberta Tuberculosis Association.

Some time ago the Association offered $1500 each to the Royal Alexandra Hospital at Edmonton and to the Holy Cross Hospital at Calgary towards the purchase of miniature x-ray equipment for the routine examination of all admissions. The equipment for the Holy Cross Hospital has not yet been delivered but, at the Royal Alexandra Hospital, the examination of the first 2,248 cases has been reported by Dr. A. F. Anderson.

The chest films of these 2,248 patients revealed:

Active Tuberculosis	2
Old Tuberculosis (inactive)	12
Pleural Effusion (probably non-tbc	4
Old Pleurisy (right base)	1
Apical Infiltration (probably non-tuberculous pneumonitis)	17
Pneumonitis	5
Metastatic Sarcoma	2
Cardiac Enlargements	3
Substernal Goitre	1
Probable Bronchiectasis	1
Large mass in Lung (metastatic?)	1
Probable Aneurysm	2

Later investigation revealed that the 17 instances of apical infiltration were really cases of pneumonitis. The findings, did, however, stimulate more thorough examination.

Other Checks Advisable

One patient admitted as suffering from rheumatic fever with little or no positive x-ray findings was discovered by sputum and other examination to have pulmonary tuberculosis. Another patient with hyperthyroidism, too ill for admission x-ray, was found post-operatively to have positive sputa. Still another, with a typical x-ray findings, thought to have a neoplasm was found at autopsy to be suffering from tuberculosis. At least two others, hospitalized during this period as suspect tuberculosis, and not included in the above, had the diagnosis confirmed by the radiologist.

At the Royal Alexandra Hospital, the Board has now decided to continue the procedure, making a small charge, probably 50 cents, to cover actual costs. Said Dr. Anderson, "Routine chest x-ray of hospital admissions is helpful from a purely diagnostic standpoint, altogether apart from the finding of tuberculosis."

The president of the Alberta Tuberculosis Association, R. W. Roscoe of Edmonton, states that the Association is prepared to conduct tests in a number of smaller hospitals in High River, Red Deer and Drumheller. Results of these tests will determine the extent of assistance rendered by the Association in future x-ray examination of hospital admissions.

A proposal is being put forth to these hospitals that, for a period of a year, they administer a tuberculin test to all admissions, using patches, and that they x-ray all reactors. The Association will supply the patches and pay for the x-rays on the basis of actual cost with, perhaps, a small additional reimbursement. It is believed, however, that the maximum should not be more than $1.00 per plate.

C. Robert Dickey, general secretary of the A.T.A., informs us that the provincial health and tuberculosis authorities have urged an extension of the A.T.A. program. St. Michael's Hospital in Lethbridge has ordered special equipment for routine chest examinations apart from A.T.A. assistance.

At the Holy Cross Hospital in Calgary and at the Edmonton General Hospital, tuberculin-negative nurses-in-training are now being vaccinated with BCG.

Ontario to Increase Grants If Ottawa Yields Amusement Tax

IT is possible that by the time this issue is in the hands of the reader a bill, recently introduced in the Ontario legislature "to impose a tax on amusements to provide greater aid to public hospitals" may have become effective. If the federal government relinquishes the present tax, the provincial government proposes to put into effect a bill levying a 20 per cent tax, from which the revenue will be placed in a separate hospital aid fund account.

As a result of this action, the hospitals of Ontario would receive grants amounting to $5,400,000 this year in place of the $2,200,000 which they received last year. It is estimated that Toronto hospitals will receive about $1,050,000 more than the $750,000 previously granted.

The province now pays $1.00 per day for every public ward bed in class "A" hospitals, 75 cents per bed in class "B" hospitals, and 60 cents per bed in class "C" hospitals. These payments are made whether or not the bed is occupied.

If and when the province is able to collect the amusement tax, these payments will be increased to $2.35 for class "A" hospitals; $1.75 for class "B" hospitals and $1.41 for class "C" hospitals.

The Honourable Leslie Frost, provincial treasurer, stated that the additional assistance should relieve certain municipalities of their large hospital deficits and that since the present contribution by municipalities to hospitals is not on a satisfactory basis, some hospitals rendering more service and having greater expenses than others, the following rates, payable by the municipalities, have been set: to class "A" hospitals, $3.00 per day; to class "B" hospitals, $2.50 per day; and to class "C" hospitals, $2.25 per day. Present rates are $2.25 per patient-day for public ward patients with certain restrictions.

Compulsory Health Insurance Proposed in British Columbia

AS WE go to press, Premier Byron Johnson of British Columbia, has announced the initial step toward a compulsory, contributory hospitalization plan on a province-wide basis. It is indicated that the Government will use the present revenue derived by the Dominion Government from the amusement tax if, and when, the latter withdraws from that field. This revenue is considered essential for maintaining sound financial operation of the hospitalization plan without placing a severe drain on the provincial treasury. While present plans are for hospitalization insurance only, it is hoped to include medical services at a later date.

The plan will be financed partly by individual contributions and partly by the Government, with the latter setting aside an extra $2,000,000 as a stabilization fund.

Individual payments will extend up to $33.00 per year per family and include children up to 16 years of age. No minimum has been set as yet for coverage of single persons, although it is expected to be $15.00 a year. Where possible, the contributions of individuals will be collected through their employers on a payroll deduction basis. Otherwise the collections will be made through a hospital insurance office.

The government contributions will include the 70 cents per patient per day now paid to hospitals and a like amount on the same basis by municipalities.

This action is being taken by the province of British Columbia because it is felt that the costs of hospital service have reached a point where the government must assume more responsibility than making contributions to hospitals. Another factor is the unsuccessful operation of a number of health and benefit societies (not the Blue Cross plan). Five associations have been suspended this year and another went into voluntary liquidation. These had a combined membership of 25,000.

Drugs and Hospital Supplies

to be a Feature of

International Trade Fair

NINETEEN drug and hospital supply companies representing Brazil, the United Kingdom, United States and Canada, will be exhibiting at the Canadian International Trade Fair in Toronto, May 31 to June 12. Surgical supports, x-ray equipment, medical and dental equipment, photographic apparatus and requisites, optical supplies and instruments, proprietary medicines, cosmetics and soaps, will be on view to buyers from all parts of the world.

Precise surgical instruments will occupy considerable space and a new type of surgical camera will be shown for the first time. In addition there will be several exhibits of modern surgical plastics and sundries ranging from elastic knit goods to ladies' powder puffs. Displays of insecticides perfected during World War II will be one of the many large exhibits presented.

Drugs and hospital supplies will be presented in the Coliseum Building in the Canadian Exhibition grounds.

Trade Fair authorities have requested that buyers of drugs and hospital supplies write for an official invitation to attend the Fair, if they have not already received one. They point out that the public will not be admitted from Mondays to Fridays and that entrance during these days will be by invitation only.

When requesting invitations buyers should state the nature of the product in which they are interested, together with their official position. Requests should be addressed to the Administrator, Canadian International Trade Fair, Administration Building, Exhibition Grounds, Toronto.

A typical open-type booth. There will be some 1,500 of these, housing exhibits from 32 countries, at the Canadian International Trade Fair, which opens May 31.

Food and Its Service

Sponsored by the Canadian Dietetic Service

Choosing and Using Kitchen Equipment

PART II

Helen E. Murphy,
Assistant Supervisor of Dietetic Services, Department of Veterans Affairs, Ottawa.

CUPBOARDS in the dietary department should be of stainless metal throughout. Too often, to keep down the initial cost while at the same time presenting a good appearance, only the front and ends are constructed of stainless metal and the back, top, bottom and shelves, are of galvanized or blue steel. It is the shelves and the inside of a cabinet which get the most wear and which require frequent cleaning with soap and water and, therefore, they should be constructed of a stainless, non-corrosive metal. The shelves should be removable for cleaning, adjustable and supported on stainless metal braces.

All cabinets should have smoothly sliding doors suspended on ball bearing wheels at the top away from grease and dirt. The bottom guides are open to prevent collection of dirt and crumbs.

Built-in cupboards, or those which extend to the floor, should have recessed toe-space to allow comfortable working conditions.

Tables and cupboards can now be constructed with sound-deadening materials. Nesting of trays and pans in cupboards should be avoided; metal racks, which allow for drainage, are now being manufactured. Trays should be filed as in a record cabinet.

Dishwashing

The newest trend in dishwashing procedure is a *pre-rinse* which not only results in cleaner dishes coming from the machine, but also saves on the amount of detergent used, and therefore saves money. Detergents act more effectively on dishes and tableware which are free of food; food particles absorb the compounds, which reduces their efficiency. A suggested improvement over the standard scraping block has been made in the form of a deep sink in the soiled dish counter. This sink must be narrow enough to permit dish racks to slide over it, and inside it is placed a wire basket which retains scrapings and any silverware dropped into it but permits liquids to drain out. Above the sink is a short rubber hose (to prevent dish breakage) attached to a water outlet controlled by a foot pedal. This type of sink reduces the bulk of garbage, which usually consists of about fifty per cent liquids, and eliminates loss of silverware.

Special machines have been developed for installation in the soiled dish counter. The procedure is to have one person pass the unscraped dishes through a gusher of warm water to pre-wash them, then the dishes are racked to go into the washing machines. Silverware, which would be lost in the old fashioned hand-scraping operation, is retained in the cutlery salvage trap, while bones float and are flushed into the scrap basket along with other garbage. Dishes last longer since they do not get the harsh treatment which often results in cracking and chipping.

Dishwashing Machines

Mechanical dishwashing machines are far from perfect but they will do a satisfactory job if properly handled, and if they are the size and type needed to handle the traffic expected of them. It must be borne in mind, though, that while these machines are called mechanical, they are still designed and operated by human beings. The efficiency of any machine is dependent on the human element and unless the operator is thoroughly trained in the operation of the machine, and realizes that contamination of utensils and dishes can still take place following removal from the machine, its efficiency breaks down.

Many dishwashing departments which are using single-tank machines would be better served with two-tank machines; the latter subjects the dishes to the wash and fresh water rinse spray available in the former type but, in addition, they receive a final rinse of fresh water from the hot water supply line. The more thorough rinsing subjects the dishes to a much higher degree of sterilization and, since more heat is applied, they dry quickly, eliminating the necessity of towelling, the possibility of contaminating the dishes with unclean towels and, because the operation is simplified, labour costs are reduced. In this type of machine the wash and rinse waters are pumped by separate pumps over the dishes in the respective tanks. Thus, the wash water containing the soil and dishwashing compound is completely separated from the rinse water, the latter being continually refreshed by the incoming final rinse water.

The temperature in wash tanks should range from 120 degrees to 140 degrees to obtain maximum efficiency for washing, whereas the final rinse water should be 180 degrees or over, in order to sanitize the dishes. Where the available hot water supply is under 180 degrees a gas-fired, or steam-operated water booster, should be installed with the machine to boost the temperature of the water for the final rinsing of the dishes.

Wherever space and funds permit, a two-tank dishwashing machine should be installed in preference to a single-tank machine.

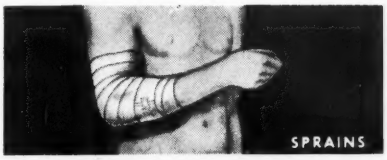
To date, three-compartment machines, that is, machines with a pre-

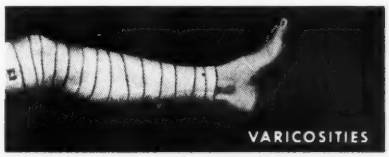
From an address presented at the O.H.A. Convention, Toronto, 1947.

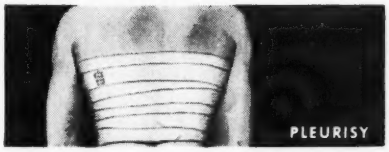
TENSOR ELASTIC BANDAGE

IS WOVEN WITH

Live Rubber Thread







● And that's the reason for TENSOR'S elasticity—TENSOR stretches to over twice its own length! *Live rubber* warp threads, sheathed in soft cotton yarn, "give" as bandaged parts move, yet provide therapeutic support. For *any* elastic bandage use, TENSOR has these advantages.

- exerts constant, controlled pressure without constriction.
- has *uniform elasticity*—rubberless bandages can't match its "stretch".
- *stays put*—no need for frequent readjustments; is comfortable to wear.
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wash compartment, are not standard equipment, but can be obtained if specially ordered. Where these are installed, dishes receive a strong flush of fresh water before entering the wash compartment. This separate compartment drains directly to the sewer and does not dilute wash water; all food particles are retained in a wire basket.

Conveyor-type machines help to eliminate the human element. In the push-through type, unless the operators remember the necessity of leaving the dishes under the wash and rinse waters the specified length of time, there is a tendency to rush the operation, with the result that the dishes are not satisfactorily washed and sanitized.

Electronic Detergent Dispenser

One of the exhibits at the annual convention of the American Dietetic Association was an electronic detergent dispenser. This dispenser was in the form of a stainless metal box, fastened to the side of the dishwashing machine, just below the level of the waterline in the wash tank. A stream of the wash water flows into the dispenser, and when the strength of the detergent in the wash tank drops, it causes a current to flow through the electrodes, which trips a lever permitting more detergent to flow into the wash tank, thus maintaining the proper strength of detergent in the tank. As yet, these machines are available only on a rental basis from the companies supplying the detergent.

Potwashing

We are continually hearing and reading about improved methods of washing dishes and cutlery, and every conscientious food operator is making an honest effort to see that proper procedures are being carried out in her department. Unfortunately, we do not hear enough of what is being done about improved methods of washing and sterilizing the pots and pans used in the preparation of food.

Potwashing sinks must have compartments large enough to accommodate the largest pot or roast pan which you have in use in your kitchen.

The most satisfactory potwashing sink I have ever seen used is one specially designed and constructed of stainless steel, in use in a university cafeteria kitchen in New York City. This is a three-compartment sink with two drainboards. The first compartment is for soaking, the second for washing, and the third, which is fitted with a steam injector and control valve, is for rinsing and sterilizing. Between the soaking and washing sinks is a section about ten inches wide, fitted with a removable, perforated skim basket. After the pot is soaked, the food particles are scraped, or brushed, into the skim basket, all grease and liquids passing through into a chamber below with an outlet to the grease trap. The pots are washed in clean, hot, soapy water in the second sink, then rinsed in clean hot water in the third compartment. The steam jet in this third compartment brings the water in this sink to a boiling temperature, and the pots are sterilized; a wire basket is used for the immersion of pots and pans, in order to protect the operator from being scalded. The clean drainboard is especially long to provide the space for pots to drain so that only a minimum of towelling is necessary. The drain in each compartment is opened and closed by means of a lever below the sink, which prevents any necessity for the worker to put his hand in the water to pull the plug. Many sinks are provided with a drain in the corner and a long pipe-like plug extending above the water-line, but this takes up space in the sink and is not as satisfactory as drains operated by a lever below. Each compartment in this particular sink has a swing-spout combination faucet, which is pushed back out of the operator's way when not in use. There is a stainless metal soap container on a swinging arm under the soiled drainboard, for the convenience of the operator.

The dietitian-in-charge at Shaughnessy Veterans Hospital, in consultation with an equipment fabricator, has devised a metal cabinet for the steam-rinsing of pots and pans. The cabinet is fitted with slanting bars, on which the pots are placed upside down to allow the water to drain out. This cabinet rests on the tile floor which has a drain. As the cabinet is not yet completed, I cannot say how satisfactorily it will work, but at least it is felt to be a step in the right direction.

Food Service Counters

As mentioned earlier in this paper, food service counters belong to the group of equipment most often built to order.

The length and number of counters to be provided depend on the number of persons to be served and upon the speed of service held desirable. There seems to be no specific standards that relate the length of the counter to the number of people to be served, although newer installations tend toward the use of short counters which are more easily supervised and require fewer workers. The counter space must be sufficient to serve without crowding and yet not so great as to over-tax the workers, or to require additional employees.

Hot counters in cafeteria lineups, whether they are steam, gas, or electrically heated, should be equipped with small shallow containers which are replaced often by other containers of freshly prepared food. Steam table inserts for baked, or prepared dishes, scallops, and other dishes of this type, should be constructed of a material suitable for oven use, as this not only cuts down on the number of containers to be washed, but the food is more attractive when displayed in the same container in which it was cooked.

Dry Heat Food Table

There is available a newer type of hot food table which is heated by either gas or electricity, and which has no water compartment. Food is kept hot by dry, hot air which means there is no resulting humidity or moisture. You have frequently seen clouds of steam escaping from a steam table, a factor which we might well attempt to overcome. The top of this table is divided into sections, each being heated by a separate burner. Therefore, rather than having all the food maintained at the same temperature, it is possible to establish the temperature in each section which is best suited for the particular food. Experience has shown that mashed potatoes stand up best at a temperature of 125 degrees, meat and most vegetables at 145 degrees, and soup should be served at 180 degrees. This can be accomplished with the newer type of hot food table. The top section can be supplied with any specified arrangement of pans, or inserts; for special diet service, one section can be obtained with twelve small inserts. At a slight additional

(Continued on page 52)

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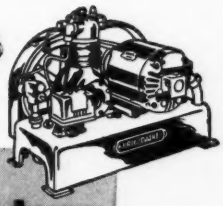

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Dr. Hincks Comments on Criticism of Mental Hospitals

THE National Committee for Mental Hygiene (Canada), through its general director, Dr. Clarence M. Hincks, last month expressed concern for the relatives of patients in Canadian mental hospitals who might have been unduly alarmed by recent charges of cruelty in these institutions. The facts as revealed by National Committee surveys in all parts of the country indicate that cruelty to patients is the great exception rather than the rule. The watchword of medical, nursing, and attendant staffs, is kindly humanitarian care and every case of physical injury to patients is investigated to discover if there has been neglect or brutality on the part of ward personnel. It may be argued that cruelty might prevail without the knowledge of those in charge. To check on this possibility, two members of the staff of the National Committee lived for a month recently in one of our Canadian mental hospitals and made ward rounds at unexpected hours of the day and night. It was found that nurses and attendants were invariably calm, tolerant and understanding, even when confronted with difficult situations arising out of the restlessness and the uncontrollable behaviour of their patients. As a further check, interviews were conducted with fifty patients who were sufficiently clear mentally to observe their surroundings and to make accurate reports of what they had seen. Not one of these fifty patients had noted any acts of violence by nurses or attendants during their stay in hospital.

It should be remembered that the 50,000 patients in Canadian mental hospitals present greater problems for treatment and care than any other grouping in our population. The enormous task that confronts the staffs of these institutions is not always fully appreciated by the public at large.

Dr. Hincks points out that the time has come when everyone must take a direct interest in the conservation of the mental health of our citizens. We must realize that our mental hospitals *are* understaffed and overcrowded and that these factors curtail individualized attention and may hamper effective treatment. Even with inadequate resources constructive work *is* being done, but to wage a really successful attack against the inroads of mental illness we need to double our expenditures. We need more psychiatric divisions in general hospitals, more mental hygiene clinics, further research in mental hygiene and redoubled support for our mental hospitals.

Nevertheless, great as our needs in this field still are, one advance which has been made is the provision of humanitarian care in our mental institutions. This fact should be welcomed by the relatives of patients in these hospitals.

Kitchen Equipment

(Continued from page 50)

cost, a small stainless metal utility shelf can be installed below the carvinb board on a hot food table, for the convenience of the operator. This would be particularly useful for utensils, wiping cloths, or additional plates.

Coffee Urns

There appears to be a difference of opinion at the present time regarding the best type of coffee urn for institutional use. The two newest types of coffee urns on the market are:

1. A stainless metal urn with an all-glass pyrex interior. A coffee bag is supported in a pyrex leacher—a leacher is an apparatus for clearing liquids from matter held in suspension, which in this case is the coffee grounds. This particular leacher has solid sides and a bottom with parallel ribs and diagonal channels, which directs and times the flow of extraction through an opening at the bottom. The greatest selling point of this urn is its all-glass interior, which gives complete freedom from metallic contamination, with its flat and bitter flavour.

2. An urn which is stainless steel inside and out, with stainless steel filter, thus eliminating the use of coffee bags and filter paper. The filter consists of two superimposed, perforated, stainless steel plates, welded together. The holes of the upper plate are above the solid areas of the lower plate, with the edges of the upper holes just touching the edges of the lower holes. The coffee liquid, draining down from the coffee grounds above the filtering surface, passes through the openings of the upper plate, then travels edgewise by capillary attraction into the openings of the lower plate, and into the liner below. Only the clear coffee brew, with all the dissolved flavouring matter gets through; coffee grounds and sediment cannot pass. It is understood from the supplier that the filter will not clog and that it is readily cleaned by rinsing in water.

With regard to the relative merits of the metal lining as compared to an all-glass lining, it has been stated that tests prove that there are more metallic substances in ordinary tap water—that is, average city water—than would ever be absorbed in the brew from the metal linings and filters, and that stainless steel linings, constructed to prevent leaks and burnt-out bottoms, need never be replaced.

In cases such as this, it is valuable to discuss the various types of equipment with persons who have used them and, from this information and your own experience, formulate your own ideas as to which is the better buy.

It is generally accepted by all dietitians and food service operators that the muslin coffee bag is old-fashioned, and that it should be replaced as early as possible by stainless metal or glass, easily-cleaned, leachers. When bags are used, some of the water passes through the porous sides of the bag above the coffee grounds line, never coming in contact with the coffee, and the brew is diluted. When filters which have solid sides are used, all the water must pass through the coffee grounds and, therefore, the brew will be stronger and the full flavour extrac-

(Concluded on page 72)

An Effective Adjunct in the Treatment of Certain Types of Tuberculosis

Clinical Experience has indicated that, as an adjunct to conventional therapy, Streptomycin is the most effective chemotherapeutic agent in the treatment of certain cases of tuberculosis. In selected cases, Streptomycin has been found effective in shortening the period of disability. The new, improved form of this valuable antibacterial agent — Streptomycin Calcium Chloride Complex Merck — provides three noteworthy advantages:

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

One of the features of English life at the present time is the amount of attention which is being paid to the history of ancient institutions. It may be due to the fact that so many have been partially or totally destroyed by enemy action that people now recognize how large a part they occupied in their daily lives, although they were only familiar landmarks and people knew little of their interiors. Nevertheless, they realize that a blank has been left in their lives. Hospital folk have had substantial cause to participate in these feelings. The consequence is that there have been considerable additions to historical literature, descriptive of organizations and buildings which have any claim to antiquity. Hospitals have made their contribution.

The principal London hospitals already had published histories in most cases, of which the most attractive example is the history of St. George's, by Dr. J. Blomfield, published in 1933. To this series there has been added a new small history of St. Thomas's Hospital. The hospitals outside London have not received attention to the same extent, so that two recent books deserve special mention. The first was published last year to commemorate the bicentenary of the Worcester Royal Infirmary, which occurred in 1945. It is the work of Dr. McMenemey and has obviously been a labour of love accomplished with a good deal of literary ability. Worcester Royal Infirmary is one of a group in provincial cities, generally cathedral cities, which enabled these voluntary bodies to carry out their benevolent desires inspired by the influence of the Evangelical Revival.

But the Worcester Royal Infirmary has other claims to notice. The prime mover in the establishment of the Infirmary was Bishop Maddox, who, in company with other ecclesiastics, aimed to provide in each county town a miniature school of medicine wherein the best apprenticeship could be served. The importance of maintaining a close association with general education was appreciated in these schemes. If the plans of the founders had been developed in accordance with their intentions, there is little doubt that the organization of medical education would be on a sounder basis than it is at the present time, owing to the over-centralization in London. This has been counteracted in order to provide a comprehensive national service.

Public Interest in History of Hospitals

Space does not allow of details being given from this very readable volume, but one other matter is of so much general interest as to require mention. One of its most distinguished alumni was Mr. (afterwards Sir) Charles Hastings, who was appointed apothecary, that is, resident medical officer of the Infirmary in 1809. Dr. McMenemy says of him that he "was destined to become the leading personality of his day in the profession of medicine and the most distinguished of Worcester's doctors." It is believed that he was the founder of the Worcestershire Medical and Surgical Society from which developed the British Medical Association. The organizing ability, for which he was noted, seems to have grown in strength to meet the increasing demands.

Besides throwing light upon some of the larger problems of medical politics, the history contains a number of entertaining items such as an appeal from the Chaplain to the management committee for books for the patients. At first they declined but under pressure from the Bishop, who thought that their reading should not be confined to the Bible, they granted £10 for the foundation of a patient's library in 1846. Some excellent illustrations add to the attractiveness of this volume.

The Northern Kingdom has, naturally, not added to the same extent to the histories of hospitals, though Dr. Logan Turner's history of the Edinburgh Royal Infirmary and Dr. Easterbrook's "Chronicle of Crichton Royal" in themselves constitute a small library of hospital historical material. There has just been added a book on a much smaller scale, but which has a particular interest. *The Story of a Scottish Voluntary Hospital,* by Dr. T. C. Mackenzie, gives an account of the principal hospital in the extreme north of Great Britain, the Inverness Royal Infirmary. Established at the beginning of the nineteenth century its relations with the local authorities have always occupied a good deal of attention. In the early days the Infirmary provided for mental patients who were, in fact, the responsibility of the local authorities. For many years of its history the provision for fever patients and the terms upon which they should receive attention were a constant matter of discussion between the managing committee and the local authorities. Now the Infirmary is the headquarters of the Highlands and Islands Medical Services, which constitutes a form of regional organization found to be useful as a model for adoption in other parts of the country under the new National Health Services Act. This set-up has attracted much attention in Canada and the United States. The book presents another aspect of hospital life and is a necessary supplement to the records of the larger hospitals in that it shows the contribution of the smaller hospitals to the whole service.

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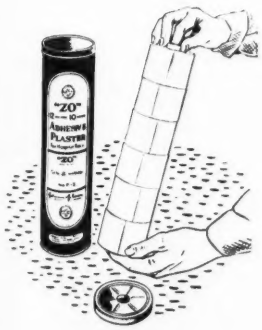

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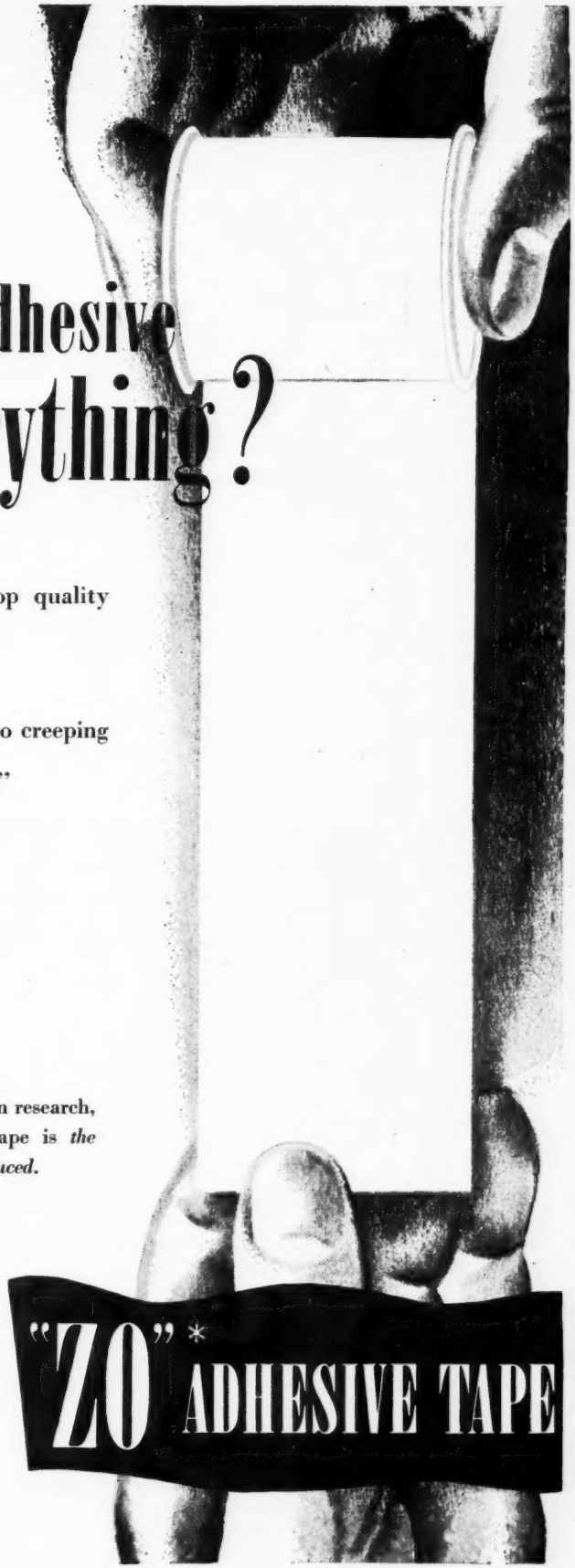

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Provincial Notes

Nova Scotia

HALIFAX. Miss Muriel Jean Graham, a native of Antigonish, has been appointed educational director at the School of Nursing of the Children's Hospital. Miss Graham is a graduate of Victoria General Hospital and was formerly a nursing sister with the R.C.A.M.C. She served in the European theatre during the last war and later went to China and Formosa in the service of UNNRA. She has taken special post-graduate courses in infectious diseases and paediatrics.

* * * *

HALIFAX. The new 400-bed Victoria General Hospital, which is now nearing completion, will house a special portrait of Queen Victoria. The picture is being forwarded from Buckingham Palace.

* * * *

NEW GLASGOW. George E. Saunders, chairman of the Board of the Aberdeen Hospital in New Glasgow, expressed grave concern over the present hazardous conditions at the hospital, due to overcrowding, and essential facilities which have fallen into a state of disrepair.

The hospital was opened fifty-one years ago, and during that time it has been enlarged or reconstructed four times, but the arrangements have all been of a makeshift nature, adding to the load of all members of the staff.

The Council was asked to recommend to the mayors of the towns that a new hospital be built, instead of spending more money on an old building that is falling down. It was estimated that the cost of a new 200 bed institution would be $2,000,000.

* * * *

SHEET HARBOUR. Plans are under way for equipping new hospitals at Sheet Harbour and in the Musquodoboit Valley by the Red Cross. Campaigns are being organized to raise funds for further hospital expansion throughout the Province.

New Brunswick

HARVEY. The Canadian Red Cross Society has officially taken over and opened the Harvey Community Hospital at Harvey Station. The building, formerly a private residence, has been remodelled and modern equipment installed.

Quebec

DRUMMONDVILLE. Last month, fire of unknown origin damaged the new hospital which is under construction. This accident will be the cause of regrettable delay and the loss involved is estimated at $35,000.

* * * *

LAC-AU-SAUMON. Les Soeurs Servantes de Notre-Dame du Clergé of Lac-au-Saumon are undertaking to construct a hospital for incurables, the cost of which is now estimated at half a million dollars. The project has been encouraged by the indefatigable zeal of the Deputy of the County, M. Ph. Cossette, and the assistance of the Minister of Health, l'hon. Albiny Paquette, who has procured a grant of $150,000 for this purpose. Plans have been drawn by M. Pierre Rinfret, architect, of Quebec City.

* * * *

QUEBEC. At the annual meeting of the Diocesan Council of Catholic Charities last month plans for erecting a hospital for under-privileged children were discussed in detail. The project is being undertaken in collaboration with Laval University and is supported by the deans of the faculties of medicine and social science and the director of the school of pedagogy. Dr. Jean-Charles Miller, president of the Committee for the Underprivileged, pointed out that in view of the exigencies of this mode of medico-pedagogical re-education, of the necessity for preparing satisfactory personnel for such an institution, and of the scientific and experimental value of such a project, it was fitting that all plans be submitted to the university authorities.

SAINT - JOSEPH - D'ALMA. The Price Bros. Company of this village, which is near Chicoutimi, have offered a contribution of $100,000 to assist in the construction of a hospital. Officials of the company and members of the municipal council are studying plans for an institution which would serve the interests of both. It is proposed to place the administration of the hospital in the hands of a religious community.

* * * *

THREE RIVERS. It is expected that the new Sainte-Marie Maternity Hospital which is under construction in this city will be completed during the summer months. The framework of reinforced concrete with brick facing is now completed as well as the interior partitions. The building is T-shape in design, the facade being 216 feet long, with a 75-foot wing at the rear. It is four storeys high with full basement as well. The hospital which is under the direction of Les Réverendes Soeurs de Misericorde, is planned to accommodate 110 mothers and an equal number of infants.

Ontario

BRANTFORD. Last month the Brantford General Hospital received a cheque for $58,000 from the Provincial government, representing half of the cost of converting the former nurses' residence to the new Terrace Pavilion. This wing will accommodate fifty-three additional patients.

The Brantford Hospital is the first in Ontario to receive settlement on the basis of 1947 legislation for grants applied toward capital cost.

* * * *

CAMPBELLFORD. Plans for the new 20-room Memorial Hospital have been altered to enlarge the building to 30 rooms, and the final costs have been estimated at between $200,000 and $250,000. Of this amount about $40,000 has been raised by the citizens, there is a town debenture of $40,000, and township debenture of $20,000, and $34,000 has been promised by the government, making a total of $134,000. The hospital will

(Concluded on page 90)

Book Reviews

140 MILLION PATIENTS. By Carl Malmberg, Chief Investigator for the United States Senate Subcommittee on Health and Education. Pp. 242. Illustrated. $3.25. Reynal and Hitchcock, New York City, 1947.

The author of this book has been closely linked with the United States Public Health Service and has been chief investigator for the U. S. Senate Subcommittee on Health and Education. He has amassed a considerable volume of statistics on illness and its cost and does reveal many of the weak spots in the present basis of providing medical care.

Unfortunately, the author is a propagandist for socialized medicine and the material included would seem to have been screened to support this objective. His case —and he presents excellent arguments for his viewpoint—would have been much stronger if he had been more objective and had presented a less biased viewpoint. His dislike of organized medicine is beyond measure, and the individual doctors are guilty of many pages of mistreatment, described under such journalese headings as "Prescription Padding", "The Cancer Patient in Blunderland", "This is Murder", "When Doctors Cause Disease", (Dr. John A. Oille, leading Canadian cardiologist, will find himself quoted here, page 111), "Poison by Prescription", "Hip-Pocket Hysterectomies", "Behind the Ether Curtain", etc., etc. There is considerable truth in what is said about sloppy medical practices, illustrated with many press and journal excerpts, but the selection of illustrations has been confined to what is derogatory and undermining. He is very critical of our hospitals, too, (p. 72) and finds that "the medieval argument that the divine order of things might be upset has been used against health insurance" by the Catholic Hospital Association (p. 181). Apparently all these weaknesses in our health system will disappear if the Wagner-Murray-Dingell bill of health insurance is accepted and put into operation.

It is to be regretted that the author has chosen to make an emotional rather than a logical presentation to his readers, for this approach weakens those sections of this compilation which in themselves would meet with general approval as, for instance, his criticism of the costly practice of self-medication with vitamins, hormones, laxatives and other products. As presented, we believe that the earlier sections of this book will be quoted extensively by the cultists, the latter sections given enthusiastic reception by those desiring state control of health, and it will probably be treated as light literature by most economists, real sociologists, and others endeavouring to obtain a true appraisal of the weaknesses and strengths of our present system and of proposed solutions.

—G.H.A.

* * * *

TEXTBOOK OF GENERAL SURGERY. By Warren H. Cole, M.D., F.A.C.S., Professor of Surgery, University of Illinois College of Medicine and Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago; and Robert Elman, M.D., F.A.C.S., Professor of Clinical Surgery, Washington University School of Medicine, assistant surgeon, Barnes Hospital, St. Louis, and associate surgeon, St. Louis Children's Hospital. Foreword by Doctor Evarts A. Graham. 5th edition. Pp. 1160. Illustrated. $11.00. D. Appleton-Century Company, Inc., New York and London, 1948.

The fifth edition of this well-known work on general surgery combines in one volume an excellent review of the whole broad field of surgery. As the authors point out, the subject matter is presented from a physiological point of view. Pathology is well described and the numerous illustrations, most of them original to this work, have been carefully selected. The details of operations are not stressed, the authors wisely leaving these data to special works on surgical technique.

In this edition the many revisions necessitated a complete resetting of the text. A chapter has been added on pre- and post-operative care, and new material included on the nutritional requirements of the surgical patient. The section on chemotherapy has been rewritten. There is an important chapter on Military Surgery, written by Dr. Frank B. Berry, Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University, and a chapter on Surgical Diseases of the Chest by Doctor Evarts A. Graham, Bixby Professor of Surgery, Washington University School of Medicine, and Doctor Thomas H. Burford, Associate Professor of Surgery in the same University. In addition, the authors have had the benefit of the advice and counsel of an imposing panel of consulting authors. The work is well written, conservative in tone and up-to-date.

Science is Fluid

Historical research has demonstrated that the history of medicine, like scientific history, is a slow but continuous accumulation and sifting of knowledge and facts, many fading with time but later brought to light again. We would cite hundreds of examples in which noting and comprehending the facts of the past has assumed significant importance in illuminating the problems of the present. No scientific progress can ever be considered as a sudden step, but each state of advancement is closely linked with achievements allied to the past. Science is fluid, it is like a spring which bubbles up and flows into a stream, then into a brook, and, together with other similar tributaries, forming a river which adds its collective force to the open sea. Continuing the simile, let us say that this scientific sea is composed of knowledge from many sources which have left their mark on their boundaries as they have made their passage on to the ultimate goal.—*Brig. Wallace H. Graham, M.D., Washington, D.C.*

Here and There

Take a Bow, Miss Fraser!

(The following is an editorial which appeared recently in the Kingston Whig-Standard).

AN editorial writer in *The Canadian Hospital*, an excellent magazine devoted to the interests implied by its title, recently upheld the values of breakfast in bed as a therapeutic and preventive measure. ("On Having Breakfast in Bed"). He thinks that fifteen minutes or half an hour spent in bed for this purpose should never be considered a sign of decadence by people proud of their apparent vitality and eternal vivacity, for the minutes so spent will help to preserve these qualities—and even life itself.

We think the writer's opinion eminently sound, and we are happy to see it advanced in a magazine which may be regarded as an authority on the subject of preventives and therapeutics. We must admit that we had never previously considered breakfast in bed from that angle, but on viewing it thus for the first time, we are thoroughly in favour of an enlarged program of personal prevention and therapy along the lines indicated.

We should like to make it clear that this enthusiasm is not a feeling suddenly aroused. We have carefully weighed the merits and demerits of breakfast in bed, and we have decided that the former considerably outweigh the latter. And we do not think we have overlooked any of the less desirable features of breaking one's fast before breaking out of bed.

One of the disadvantages of breakfast in bed is the relative ease with which the coffee may be spilled, and this we find, is frowned on by those who serve the breakfast. Applying the proper pressure to a grapefruit to get the last ounce of juice, a little too much effort in cutting a slice of ham—and over goes the coffee. Toast also brings its problems—crumbs in the bed, which create a condition to be dealt with only by applying the principles of yogi or remaking the bed. This business of crumbs in the bed is probably the greatest disadvantage, and it can be very wearing on others. We recall vividly an experience with a child convalescing from scarlet fever; the little darling would eat nothing but iced animal biscuits. His demands for these were punctuated only by his howls that crumbs were lacerating his tender flesh and by all too infrequent intervals of sleep. And then, of course,

another disadvantage is that the breakfaster is usually handicapped by being too far from the source of supply if a second helping seems indicated.

Granting these disadvantages, however, we're all for breakfast in bed. In the words of Sir Harry Lauder's famous song, "it's nice to get up in the morning—but it's nicer to stay in bed". And it's much nicer to stay there full fed, instead of being prodded out by the gentle urgings of hunger from the good smell of coffee and bacon being prepared elsewhere.

Then and Now

Some years ago Dr. T. G. H. Drake of this city unearthed some old regulations of the General Hospital of St. Jacques de Toulon dating back to 1775. One of these rules stipulates:

"If the patient dies while in Hospital all that he has brought with him on admission shall become the property of the Hospital, the clothing to be distributed to needy cases on discharge or sold for the Hospital's benefit."

And another, indicating the very modern viewpoint of the administration:

"No more than one patient shall be placed in each bed, at least not until all the beds are occupied . . ."

Interns, or garçons, were required to be in for the night before eight in the winter and nine in the summer.

Modern Construction Trends in an Age Long Past

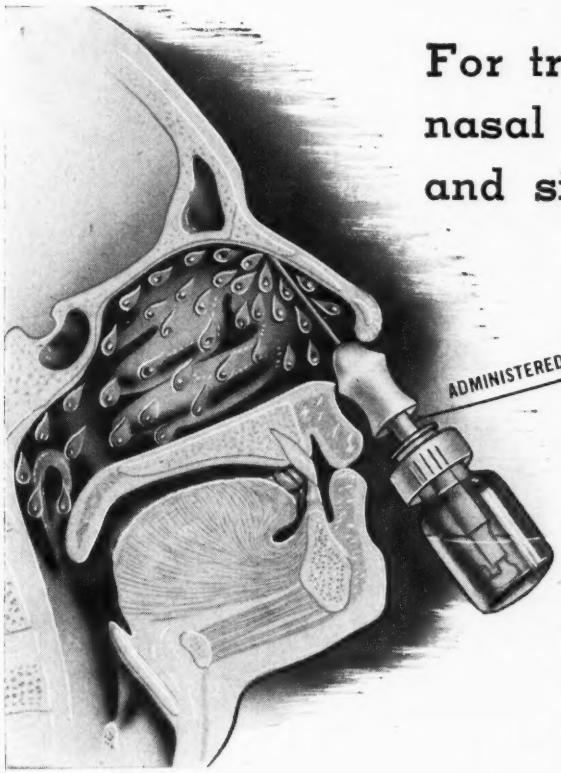
Writing in *Medical Life* (43:1. p.10) Dr. R. A. Kilduffe of Atlantic City notes that Charaha, a physician of India, several hundred years before Christ, had given a description of hospital construction:

"The building of the hospital should be strong and not exposed to strong winds. Every part of it should have access to plenty of air, that is, freely ventilated and spacious enough for walking about with ease; not too near any high or large buildings or obstructions; not exposed to smoke, sun, moisture or dust; and not exposed to injurious sounds, feelings, forms, tastes or smells."

Britons Would Seek Fame in Medicine

Pollsters asked British people: "If you had the choice of being famous in one of these careers (listed on a card), which would you choose?" They voted: doctor, 21 per cent; musician, 18 per cent; head of big company, 11 per cent; writer, 10 per cent; scientist, 9 per cent; movie star, 6 per cent; football player, 5 per cent; Prime Minister, 2 per cent; none of them 17 per cent; no reply, 1 per cent.

In a somewhat similar American poll, medicine also came out on top with 25 per cent of the votes. Runners-up were engineering, law, farming, clergy, business and teaching.



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Supplied in 1 oz. bottles, with or without Jetomizer.

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With the Auxiliaries

Saint John Hospital Aids Hold Annual Meeting

The annual election of officers and social gathering of women's hospital aids in Saint John was held at the nurses' residence of the General Hospital on March 4th. Mrs. C. H. Wiley, vice-president-at-large was in charge of the meeting. In addressing the group, Mr. R. H. Gale, superintendent of the hospital, suggested as a motto, "Plan your work and work your plan". He asked the aid members to continue their good work in showing hospitality to nurses in training of whom there are now 150 at the hospital. Those present inspected the rumpus room in the residence which the aids have helped to furnish.

Among other activities of the aids mentioned were: the collecting of magazines and books for patients both at the General Hospital and the Tuberculosis unit; decorating 48-ounce fruit juice tins for use as vases in the hospitals; and the provision of cookies and home-made candy as Easter treats for patients.

* * * *

"Nearly New Shop" in Montreal a Profitable Undertaking

According to the annual report of the president, Mrs. C. Nelson, the "Nearly New Shop" run by the Women's Auxiliary of the Children's Memorial Hospital in Montreal is a most profitable concern. During the past year it has netted $3,125.00.

Mrs. Nelson indicated that the auxiliary plans to spend $6,000 this year on hospital equipment alone. The items urgently required include a ceiling light for the operating room, an oxygen analyzer, a cash register, an adding machine and a dictaphone.

A form of service recently inaugurated by this active group is the taxi fund—a service set up to provide transportation to and from clinics for indigent and incapacitated patients. Members of the auxiliary have also given hours of work to assist the newly re-opened social service department of the hospital, as well as doing clerical work in the clinics, the admitting office of the out-patients department, and the library.

* * * *

During Past 25 Years Aids have Contributed $4,000,000

In an address to the students in hospital administration at the University of Toronto last month, Mrs. Margaret Rhynas, public relations administrator of the Women's Hospital Aids Association of Ontario, said that during the last twenty-five years the sum of $4,000,000 had been contributed to Ontario hospitals by the affiliated voluntary auxiliaries. Mrs. Rhynas added, "It is now the exception, rather than the rule, when women's hospital auxiliaries are not represented on hospital governing boards".

* * * *

President Visits Aids In Various Cities

Mrs. J. Graham Harkness, President of the Women's Hospital Aids Association of Ontario, recently attended meetings of the local Aids at Cobourg, Belleville and Picton. Each Aid had planned special activities for the President's visit. Later Mrs. Harkness paid a call on the four Aids in Windsor—at the Metropolitan General, Grace, Hotel Dieu and East Windsor Memorial Hospitals. At this time a joint meeting of all hospital Aid workers was held and Mrs. Harkness was presented with an Honorary Life Membership by each Aid.

Many invitations have been extended to the President by other Aids and she is planning a number of visits of this nature during the coming months.

* * * *

Belleville Aid Presents Annual Fashion Show

Last month the Auxiliary of the Belleville General Hospital achieved another marked success in the presentation of their annual spring fasion show at the Capitol theatre in that city. Mrs. G. H. Stobie acted as commentator and Mrs. W. P. Wareham, pianist, furnished a background of music. The president, Mrs. Gilbert Scott, was introduced by Mrs. Stobie. Mrs. Scott expressed her gratitude to all who had assisted in organizing and presenting the show, and gave an outline of the valuable work of the auxiliary. A capacity audience attended in both the afternoon and evening and over $600.00 was realized.

* * * *

Princess Elizabeth Guild Organized in Winnipeg

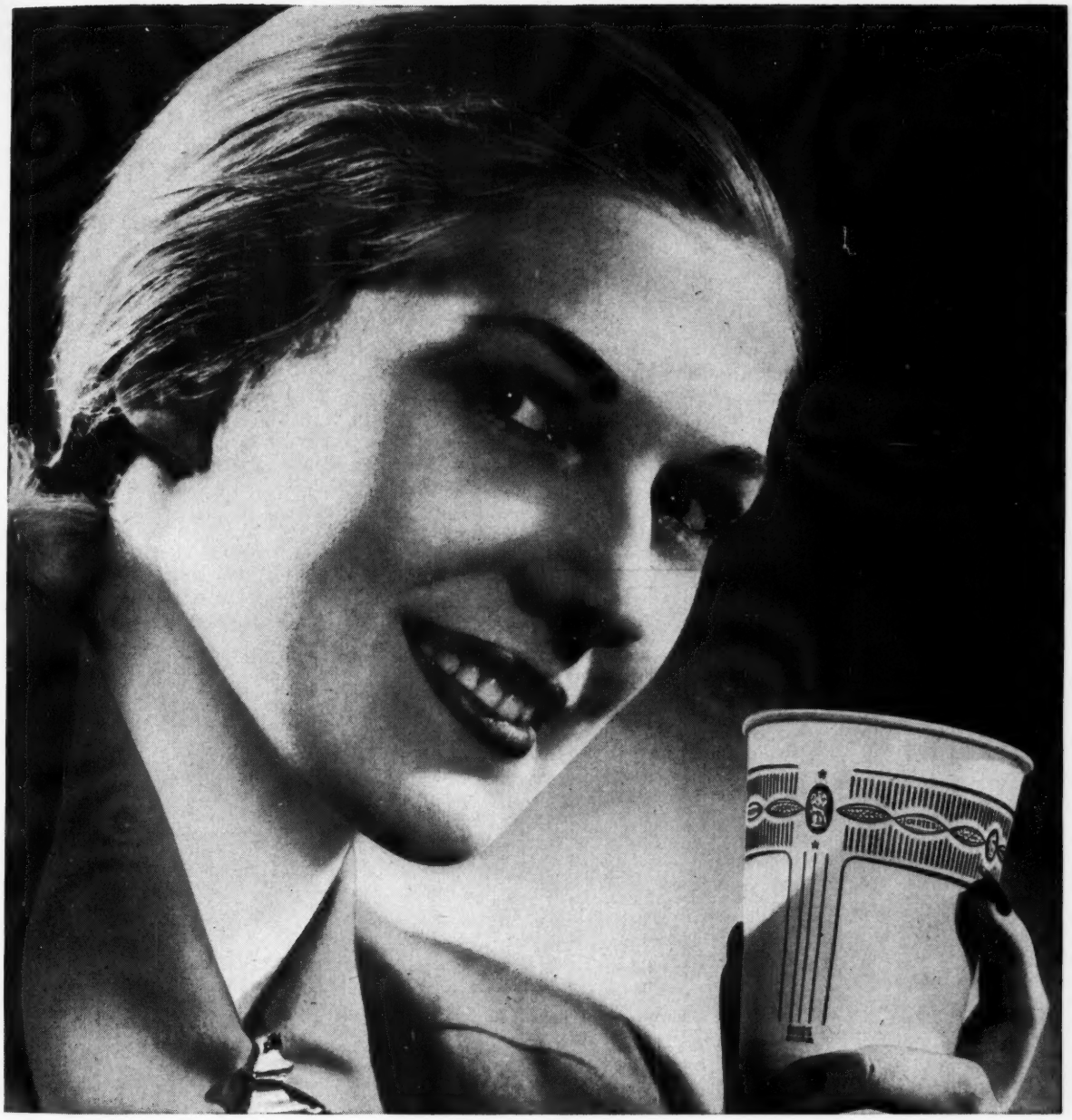
The women of south Winnipeg have formed a guild designed to serve the Princess Elizabeth Hospital, the proposed new unit of the Municipal Hospitals. At the inaugural meeting of the guild or auxiliary, Mrs. J. W. Ellinthorpe was appointed chairman pro tem and Mrs. S. Cruden, secretary. The group will devote its services to the King George Hospital until the new structure is completed.

* * * *

A Tribute To Ladies' Auxiliaries

A very essential unit in the successful operation of any hospital is the Ladies' Auxiliary which represents an energetic group of women who give voluntarily of their time and service to the welfare of the institution.

The wise hospital administrator can be of great assistance in directing, and co-operating with, this organization for it can be of inestimable value to the hospital, not only in financial matters, but also in promoting interest and good will. Many misunderstandings can be avoided if the administrator will attend their meetings, and help them plan their programs. In their laudable work, these devoted women should receive every encouragement and co-operation from the governing board as well as from the administrative staff. Often they supply necessary equipment and furnishing, which the hospital could ill afford, and they take a justifiable pride in their worthwhile achievements. If the amount contributed by the Ladies' Auxiliaries to the hospitals in the Maritime Provinces over a period of years were calculated, it would unquestionably exceed that of any philanthropist.—*Rev. Mother Ignatius.*



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Health Care Plans

Blue Cross Extends Benefits to Small Groups and Organizations

It has been announced by D. W. Ogilvie, deputy director of the Ontario Plan for Hospital Care, that applications will now be accepted from employee groups of three or more persons, providing that management participates in enrolment. Mr. Ogilvie further states that organizations established for other than social or recreational activities, and with a reasonably permanent membership, such as lodges, women's institutes, associations, et cetera, may now enrol through a special group if there is not a Blue Cross group at place of employment.

This extension of benefits is part of the Plan's desire to make its protection available to as many people as possible. The former minimum requirement of five, enrolled through place of employment, ruled out many small groups.

* * * *

New Surgical-Medical Plan for P.E.I. and Newfoundland

The Maritime Hospital Service Association is now offering to the residents of Prince Edward Island and Newfoundland a complete health protection plan covering hospital, surgical, medical and maternity bills.

The additional protection will be available to all who are presently members of Blue Cross and to those who subscribe for hospital protection. It will be offered on a three point basis. The individual must first subscribe for hospital protection, and to this he may add surgical protection, and to the combined hospital and surgical protection may be added medical protection. Thus three types of contract will be available: hospital, hospital-surgical, and hospital-surgical-medical.

Group rates for hospital protection are 75 cents and $1.00 a month for individuals, $1.45 and $2.00 per month for families. The new surgical protection which covers operations and surgical procedures in the hospital, the doctor's office, at home, and in case of emergency at any location, will be 65 cents a month for individuals and $1.90 a month for families. Included in this are maternity benefits which allow for the payment of $50.00, or more in difficult cases.

The medical protection contract which may be purchased in addition to the hospital and surgical contracts, and which allows for payment of $3.00 per day for a period of twenty-eight days to cover medical services while in hospital, will cost 40 cents a month for the individual and $1.00 a month for families.

* * * *

High Birth Rate Cause of Increased Expenditure by M.H.S.A.

The annual report of the Manitoba Hospital Service Association for 1947, which has recently been issued, indicates that the year was marked by a steady increase in membership, heavy utilization of hospital care, and continued rising costs in the administration of hospitals.

The greatly increased cost of hospital care was due in part to the extraordinarily high birth rate involving the Association in an expenditure of $284,959.62, covering 6,857 maternity cases. The polio epidemic brought 349 patients whose hospital care cost $14,253.14.

The new rates established by the Board of Trustees as of the 1st of October, 1946, became effective during the year as subscribers' contracts came up for renewal and by September 30th, 1947, all contracts carried the increased rate. The new rate structure provided sufficient income to meet all outlays but was inadequate to build up a contingent reserve. The report further states that, if the present upward trend in commodity prices continues, another increase in subscription fees may become unavoidable.

At the close of the year, membership of the Association consisted of 102,711 subscribers with 147,529 dependants, or a total of 250,240 participants; more than one-third of the population of the Province. This enrolment represents a net increase for the year of 8,842 contracts and 22,761 participants.

During the year the Association covered hospital accounts of 34,825 discharged patients at a cost of $1,415,919.81 in hospitals throughout Canada and the United States.

To meet the keen demand of citizens in the low income bracket the Association has offered a low cost plan for general ward service as an alternative to the semi-private plan operation.

* * * *

Quebec Blue Cross Continues to Expand

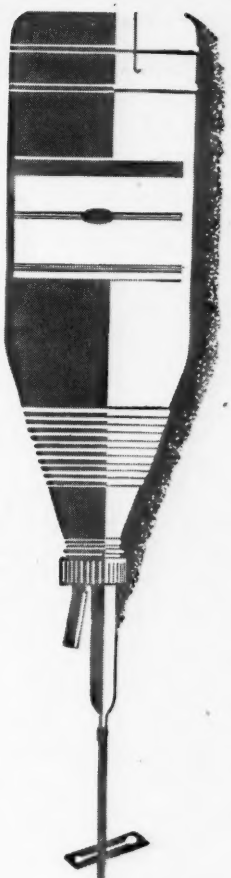
Continued public demand for Blue Cross services was reported at the annual meeting of the Board of Governors of the Quebec Hospital Service Association, held in Montreal, as Mr. H. C. Hayes, Chairman of the Board, discussed the year's activities. "At the end of 1947", Mr. Hayes revealed, "331,929 persons representing about 10 per cent of the population of the Province of Quebec were participants in our hospital service. During the five years and eight months of the Plan's operation, 82,695 members have been hospitalized for 703,670 days, and the Association has paid $4,416,162.54 to the hospitals.

He added, however, that "while the enrolment and financial results of the over-all operations for 1947 were gratifying, the rapid rise in hospital costs during the year, together with further possible increase, are causing grave concern to the executive". "Our hospital contract", continued Mr. Hayes, "is designed to pay hospital charges for a specific period and is not a limited liability contract, therefore, each successive increase in hospital rates throws a serious additional burden on the Association."

Reviewing the entire picture, Mr. E. D. Millican, Executive Director, stated that the Association had successfully launched its new surgical and medical plans which had been well received by existing subscribers, while new members were being accepted continuously. Mr. Millican quoted the following figures: 877 new groups formed, 161,872 enrolled

(Concluded on page 88)

A complete **parenteral program** *for every general hospital*



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2. Anticoagulants and Blood Preservatives

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Intravenous Solutions *and* Venoclysis Equipment

Correspondence

Meeting the Nurse Shortage

To the Editor:

It appears to me that the immediate problem is solving itself. Maids and nurses' aides are taking over a large portion of the work formerly done by nurses and the supply of maids and nurses' aides locally appears to be quite adequate.

In the event of a war or other national emergency within the next quarter of a century, it would appear that the nursing situation could be helped materially if the Federal Government immediately conscripted the services of trained nurses. There must be a tremendous backlog of those in the country at the present time. Personally I do not think the supply will ever reach the point where those actively engaged in nursing will be adequate in numbers to meet a national emergency, and also provide for the usual current demand.

Yours very truly,

"A. C. McGugan",
Superintendent,
University of Alberta Hospital.

* * * *

Time for Plain Speaking On the Nursing Shortage

To the Editor:

If we are ever to get someone to find a cure for the present unsatisfactory nursing situation, we must get down to fundamental causes. I am of the opinion the basic cause of the present lack of action towards a cure is the vacillating attitude of the hospitals.

The hospitals are actually doing the work, while at the same time they are saying it is not their responsibility. Their words contradict their actions. This seems to me like the man who, having been knocked down by assailants who proceeded to kick him while he was down, refused to defend himself on the grounds it wasn't his fault that he was being kicked.

I agree that later a comprehensive survey of the whole nursing field may be necessary, but for this to be effective it must be preceded by a move on the part of the people who are carrying the load today. They must make it known whether they wish to continue or not. If they do wish to continue, they should stop saying they are not responsible. If they do not wish to continue to carry the basic responsibility and the initiative, they should not only say so unequivocally but should be prepared to back up their statements by their acts.

I do not think the hospitals should side step. I think they should be very vocal if they want someone else to take the load off their shoulders. They should be direct and specific in the statement that they do not intend to carry the load any longer, if that is what they really wish.

I think it is time to come out of the forest and survey the situation as a whole from an adjoining hilltop.

Yours truly,
"Percy Ward"
B.C.H.A.

* * * *

C.S.R.T. Convention

To the Editor:

Would you be kind enough to extend through your journal a hearty invitation to your readers to attend the Convention of the Canadian Society of Radiological Technicians which will be held at the Chateau Frontenac, Quebec, from June 17 to June 19.

Thanking you for this courtesy,

Yours very truly,
"L. J. Cartwright"
Editor, The Focal Spot.

Three More Institutes Planned by A.H.A.

The American Hospital Association has announced three more Institutes to be held in May:

The first Institute for Hospital Engineers will be conducted May 24-28 at the Knickerbocker Hotel, Chicago. Several sessions will be allotted to new developments in the field of hospital plant operation and maintenance. A review of basic data for experienced engineers as well as interchange of information on practical shortcuts and "tricks of the trade" will be a second feature. There will also be valuable discussion on radiant heating, hospital lighting and electronics.

An Institute on Hospital Public Relations is planned for May 31 - June 4 at Westminster Choir College, Princeton University. The Institute has been arranged to present basic information and discussion for administrators and public relations people new in the field as well as for those with more experience. Experts from hospitals, press, radio and business, will take part. Registration will be limited to 100, and applications should be sent as soon as possible to the Council on Public Relations of the A.H.A.

The Institute on Hospital Purchasing, scheduled for May 17-21 at the Shirley Savoy Hotel, Denver, Colorado, will feature a faculty of highly qualified hospital purchasing personnel as well as speakers from allied fields. Special attention will be given to basic purchasing concepts, and their application in effective hospital operation, for the benefit of administrators and purchasing officers from smaller hospitals where separate purchasing departments are not possible. Applications should be forwarded, with the $25.00 registration fee, to Leonard P. Goudy, Purchasing Specialist, A.H.A., 18 East Division Street, Chicago.

American Psychiatric Association Appoints Medical Director

Dr. Daniel Blain, formerly Chief of Neuropsychiatric Services for the Veterans Administration of the U.S.A., has accepted the newly established position of Medical Director of the American Psychiatric Association. The post has been created in order to provide the full time services of a medical man who will act for the Association as an authorized source of information and advice.

Dr. Blain's services will be made available to the membership, to affiliate societies and to public and private organizations interested in the field of psychiatry. He may be addressed at the executive office of the Association, Room 924, 9 Rockefeller Plaza, New York City 20. Later he will have a permanent office in Washington.

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MEDICAMENTA VERA

Care of Roofs

ROOFS are, perhaps the most vulnerable of all exterior surfaces to the effects of weather, and care is always necessary in the selection of materials for coverings to ensure adequate durability and reasonably low maintenance cost. It is important to know that different types of roof-covering are more or less susceptible to varying weather conditions. There is no universal criterion for all materials.

Every roof should receive regular inspection. Some roofs need only be inspected occasionally, but others should be inspected monthly, or even weekly. The downspouts should be gone over and then the main body of the roof. All loose papers, sticks, and other débris should be swept up and removed as this interferes with drainage.

When inspecting the roof, make the following check-ups:

1. Copings. Many leaks start where mortar joints in coping crack. Also, copings of porous concrete, stone or cast stone absorb water that may leak into the lower hall.

2. Parapets. Leaks from open points or from porous masonry may have weakened parapet walls.

3. Flashings. Look for punctures and rips.

4. Skylights. Wood sash rots, or steel rusts.

5. Rust. Spring painting is very essential.

The building manager is periodically faced with the necessity of deciding when to patch or repair a roof, when to recoat and when to install a new roof. If a relatively good composition roof gives trouble within three years, the difficulty should be corrected by repairs. If more than three years old and there are leaks at various points, it is time to recoat the roof, unless the roofing has cracked. If cracking is extensive, it is better to install a new roof. When a new roof is put on, both workmanship and materials must be checked. The best safeguard is a responsible contractor.

One reason for the popularity of tar and gravel roofing lies in its flexibility. The water-proofing quality of these roofs is obtained by applying the tar in a molten state, so that it flows into all cracks and tight against all interrupting surfaces. The life of a tar and gravel roof lies largely in the gravel which serves as a protection for the felt. Except for the gravel used with the tarred felt, there is little difference between it and an asphalt roof with respect either to cost or life.

These roofs will deteriorate as the oils dry out. The oils can be renewed by treating the roof with a liquid made for the purpose. Loose pebbles or minerals are swept into piles. The liquid is applied over the pebbles or mineral remaining fast. As each section is treated, the loose pebbles are swept back over the new coating. Ripped and torn parts can be secured with plastic roofing cement. Should there be blisters in the roofing, a slit should be made in the centre of the blister. Plastic roofing cement should be spread heavily on the surface beneath and the blister pressed back. Place weights on top of the repaired blister for a few hours.

Asphalt slate shingles and roll roofing will become brittle after some years of exposure. The dried-out oils can be renewed by brushing with a compound made for the purpose.

Heavy-weight prepared shingles will not be disturbed by strong winds, while light-weight shingles will be lifted. The shingles can be secured to the roof by a small application of roofing cement under the free ends.

Nails along the edges of strips of roll roofing will occasionally cause leaks by backing out. To secure these nails, tear light-weight cotton sheeting into three-inch strips. Fasten these strips over the nail heads and margins of the roofing with liquid roofing cement. Then apply plastic roofing cement on top, using a putty knife.

A tin roof must be kept painted for protection against rusting. Red lead paint is commonly used. Another preservative coating for a tin roof is liquid asphalt roofing cement. Holes can be closed with a plastic roofing cement.

To replace broken slate, nail one end of a piece of copper at the bottom of the place left bare. The slate is slipped into position under the slates of the course above, and the free end of the copper strip is folded over its lower edge to hold it in place.

A leak in a shingle roof can be located by examination of the under side during a rain. If there is no rain, use a hose. The path of the water should be traced back to the leak. A leak from a shingle that is split or otherwise defective can be closed with a piece of single-ply tar paper, 3 or 4 inches wide and 6 inches or more long. The end of the defective shingle is raised slightly, the paper slipped under and secured with a dab of roofing cement.

A badly curled shingle should be flattened by splitting. Place a piece of tar paper beneath the split and nail the exposed ends of the shingle, using galvanized or copper nails.

When wood shingles are so far gone that a new roof is needed, there are definite advantages in placing it on top of the old roof rather than tearing it off. Stiffness and heat resistance will be increased; dirt inside and outside will be avoided, and there will be a saving in labour. Any roofing material of ordinary weight can be used for the new roof; wood shingles, asphalt-slate shingles, or asbestos shingles.

Rain blows under roof shingles and there will be rotting if they can not dry out. Drying is quickest with unfinished shingles but with no protection the natural oils dry out and the shingles are likely to curl and split.

For long service, roof shingles should be treated with a preservative. A preservative penetrates the fibres, but does not greatly check the drying out of moisture. Paint, on the other hand, closes the pores, drying is retarded and rotting is likely to occur. Paint can be used on side wall shingles for, on a vertical surface, drainage is so complete that water does not penetrate beneath. For roof shingles, stain or oil should be used.

Commercial stains are not usually as effective as preservatives. A stain

(Concluded on page 76)

Supply of Nurses

(Concluded from page 27)

Of the hospitals? Of the doctors? Or of the people as a whole?

The Canadian Hospital Council through its Executive Committee, through its Committee on Nursing and through the Joint Committee studying the nursing situation, has given this subject much thought and is firmly convinced that this problem has now become of such national importance that it can no longer be left to the nurses, to the hospitals or to the doctors, to work out the answers.

Certainly it is not fair to place this responsibility upon the organized nursing profession which has done all that is humanly possible to increase the output. Few others in a group-conscious society would have done as much to dilute the demand for their own services.

And most emphatically it is NOT the responsibility of the 169 hospitals large enough to operate schools of nursing. Unlike other educational institutions they do not receive one cent of assistance for the training provided. This was logical in the days when a school was a financial asset, but higher standards, obligatory affiliations, and higher cost of maintenance, have materially changed that picture.

Hospitals with schools of nursing could meet their own and other public hospitals' needs with ease, but they cannot be expected to bear unaided the burden of providing the many nurses required for industry, for Department of Veterans Affairs, for provincial and municipal health departments and for doctors' offices.*

The responsibility for maintaining an adequate supply of nurses to furnish health care for the people of this country rests with the people themselves. And that means with the respective governments — federal, provincial, and municipal. It rests, too, with industry and labour which absorb a goodly share of the output of our schools of nursing. And it rests with parents who cannot expect other people's daughters to work on Saturdays and Sundays and on Christmas Day while they continue to discourage their own daughters from entering this fine profession.

It should be clearly realized by all that the hospitals alone cannot continue to assume the responsibility for maintaining an adequate supply of nurses in this country.

It has become obvious to the Joint Committee studying this subject that they, or their associations, alone cannot effect a solution. In the first place it would be exceedingly difficult for hospitals and for nurses to make an objective approach which might lead to recommendations affecting adversely some of the institutions or individuals participating. In the second place, recommendations by the interested parties involved, no matter how sound and logical, seldom receive adequate attention either from the public or from the governments.

As a satisfactory solution of this problem is of vital concern to the public, *the public should be well represented,* on any committee making recommendations, by outstanding citizens whose judgment commands general respect.

Moreover, as any worthwhile recommendations may well involve revisions in governmental regulations and, in all probability, in financial assistance, *the government should be very much a party to these recommendations.*

The Present Set-up

(a) As it now stands the Joint Committee is of the opinion that it has gone about as far as it can by itself. It has recommended the setting up of a broad National Committee or Commission, with adequate representation by the public and by the federal and provincial governments. The hospitals, the nurses and the doctors would be only part of the new study committee. This committee or commission would study the whole subject from every angle, as already mentioned.

(b) It has been recommended that this study should be financed jointly by the federal and provincial governments, inasmuch as the study is of vital public interest and concern.

(c) The Joint Committee presented a memorandum to the Minister of National Health and Welfare in February, 1947, outlining the desirability of an extensive study and requesting financial support for this study. In September of that year the Canadian Nurses Association presented a comparable memorandum, incorporating an excellent review of the situation over the years, to the Deputy Minister of Health in each province.

(d) The proposal was presented to the Dominion Council of Health in October, 1947, inasmuch as that body is made up of representatives of the federal and provincial departments of health. No definite action was taken.

(e) The Department of National Health and Welfare takes the position that this is a matter which comes under provincial jurisdiction and, therefore, suggests that these committee studies and recommendations be worked out in the provinces first.

(f) This suggestion has been passed on to the provincial and regional hospital associations and conferences. (Manitoba has already taken this step.)

(g) As there are distinct limitations to the action which may be taken within any single province (e.g., revision of the basis and scope of nurse education might isolate a province professionally), and as there seems to be a widespread inclination to leave it to the hospitals and the nurses to work out the solution for a situation which is primarily the concern of the public itself, the Executive Committee of the Canadian Hospital Council has approved the publication of this statement.

According to the 1943 survey only 48.4 per cent of employed nurses were on the staffs of hospitals or schools of nursing.

The Public Lottery Pest

New York City's council has passed a resolution asking of the state legislature authority to set up "a one-year lottery" to raise $100,000,000 for the city's hospitals. Let us hope the state legislature steps on this scheme with a heavy foot. The United States used to be plagued with lotteries, but the last of them disappeared in 1890 when the once-famous "Louisiana Lottery" was put out of business. Since then government lotteries have been left to some of the South American countries, to Mexico, and to Eire—and some of the results are deplorable. It is hard to believe that responsible opinion in New York state will favour turning back the clock. A lottery is a scheme for enriching a few at the expense of many suckers, and the morals of it are not improved by official sponsorship.

—From the Ottawa Journal

AM-8-1

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Try it on wools, flannels, silks, rayons —*any* risky washing job! See for yourself how quickly, how easily it washes —how thoroughly it protects your customers' precious belongings.

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- ★ Practically eliminates color bleeding, can be used in mild acid or salt solutions.
- ★ Works equally well in hard or soft water.
- ★ May be used safely on garments of open weave, or loosely spun yarn.
- ★ Dissolves quickly—rinses completely.
- ★ Colored silks and rayons stay fresh and clear.

FOR YOUR RISKIEST WASHING PROBLEM... *USE*

ARCTIC SYNTEX "M"

FREE BOOKLET: "30 WAYS TO CLEAN BETTER WITH ARCTIC SYNTEX 'M'". Write Dept. V. 20

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MONCTON • QUEBEC • MONTREAL • OTTAWA • WINNIPEG • REGINA • CALGARY • VANCOUVER

Kitchen Equipment

(Concluded from page 52)

ted. There are no coffee bags to lie around and become rancid and no chance of any bag being used too often, resulting in bitter, poor quality coffee. These metal filters can be procured to fit any size of urn.

Faucets on urns must be of simple construction, easily taken apart and cleaned.

The number and size of urns to be installed depends on the number of people served and on the type of service in use. Urns can be obtained for use with steam, gas or electricity. It is wise to pay a little extra and have thermostatic control, thus assuring proper serving temperature and saving fuel. When a thermostat is used there is no necessity for the coffee to boil. It is appreciated that coffee is best when it is made often and in limited quantities. For this reason, if space permits, it is wise to instal a battery of three urns of smaller capacity in preference to one or two large urns. In this way, coffee can be made in the second urn just before the first urn is emptied and the coffee need not be brewed too far in advance of the time it is served.

It has been found that where possible coffee should be made in or near the service area. Very often this is not practicable, and it is necessary, for one reason or another, to make the coffee in urns in the main kitchen, then transport it to the various service areas in the hospital. Frequently unsightly and unsanitary, chipped, uncovered enamel jugs, are used to transport the coffee which becomes cold by the time it reaches the patients. To offset this, there are many types of thermos jugs available at the present time. Some of our institutions use portable, stainless steel, thermos urns which are taken to the main kitchen to be filled, returned to the diet kitchen, and placed on a small stainless steel table on castors. This urn is then wheeled into the ward along with the food truck and tray carriers, and each patient is assured of a hot cup of coffee. Under the tap on the stand is a small drip pan which receives any drips that might otherwise be spilled on the floor.

Toasters

The automatic pop-up type toaster or the conveyor type are the only practical institutional toasters yet devised, as they eliminate continual watching and timing by the operator. This not only reduces labour but, since the toasters are entirely automatic, they eliminate the possibility of bread wastage by burning.

Other Equipment

Every institutional kitchen should have as part of its equipment, and located in a convenient area in the kitchen, the following:

1. A hand-washing sink, with pedal or knee-controlled faucets.

2. A drinking fountain, also pedal or knee-controlled. This eliminates having used cups left on the vegetable, meat, or potwashing sinks, and the possibility of even ladles and dippers being used as drinking utensils.

3. Some fire extinguishing equipment. Carbon dioxide is an invaluable fire extinguisher for the kitchen because it is quick and will not harm foods. It is stored in cylinders as a liquid and, when released by a valve, an inert gas expands and smothers the fire in a matter of seconds. Portable carbon dioxide extinguishers are available in various sizes and designs. Periodic check-ups on protective devices and good housekeeping standards are extremely important in fire prevention in institutional kitchens.

Illness As a Contingency

Concluded from page 34)

breviated *hospital shirt*. Some uniforms flatter one's ego. They suggest rank and accomplishment but a hospital shirt, utilitarian as it may be, is not one of them. The process of getting ready for a stay in the hospital is not calculated to bolster one's ego. Little secrets which the fastidious woman thought to share only with her dentist and beautician and others must be shared with the nursing staff. The intern arrives to take the admission history. Questions are asked which to the patient seem unduly personal and intimate. The physical examination to her, seems to entail undue exposure and embarrassment. The history-taking, if not skilfully conducted, may take the form of a cross-examination. Finally, there are those painful and irritating procedures, the taking of blood, and spinal puncture and perhaps the insertion of a duodenal drainage tube. Can we wonder that, in spite of all our efforts, the patient is glad to leave us?

Much distaste for hospitalization can be prevented if the reason for every question and every procedure is explained and worry can be prevented if the causes are understood, anticipated and removed by adequate explanation.

May I say that this discussion, essentially, has been a plea for a study of each and every patient and every friend and relative as an individual.

It is a plea for intelligent sympathy based on psychological study. Of course, it means more work but what of that! Personally I am rather intolerant of the growing trend towards what may be designated the acquisitive attitude in groups which formerly were pure professions. I have little sympathy with those who look for more authority with less responsibility, more pay with less work, and the eternal search for softer jobs.

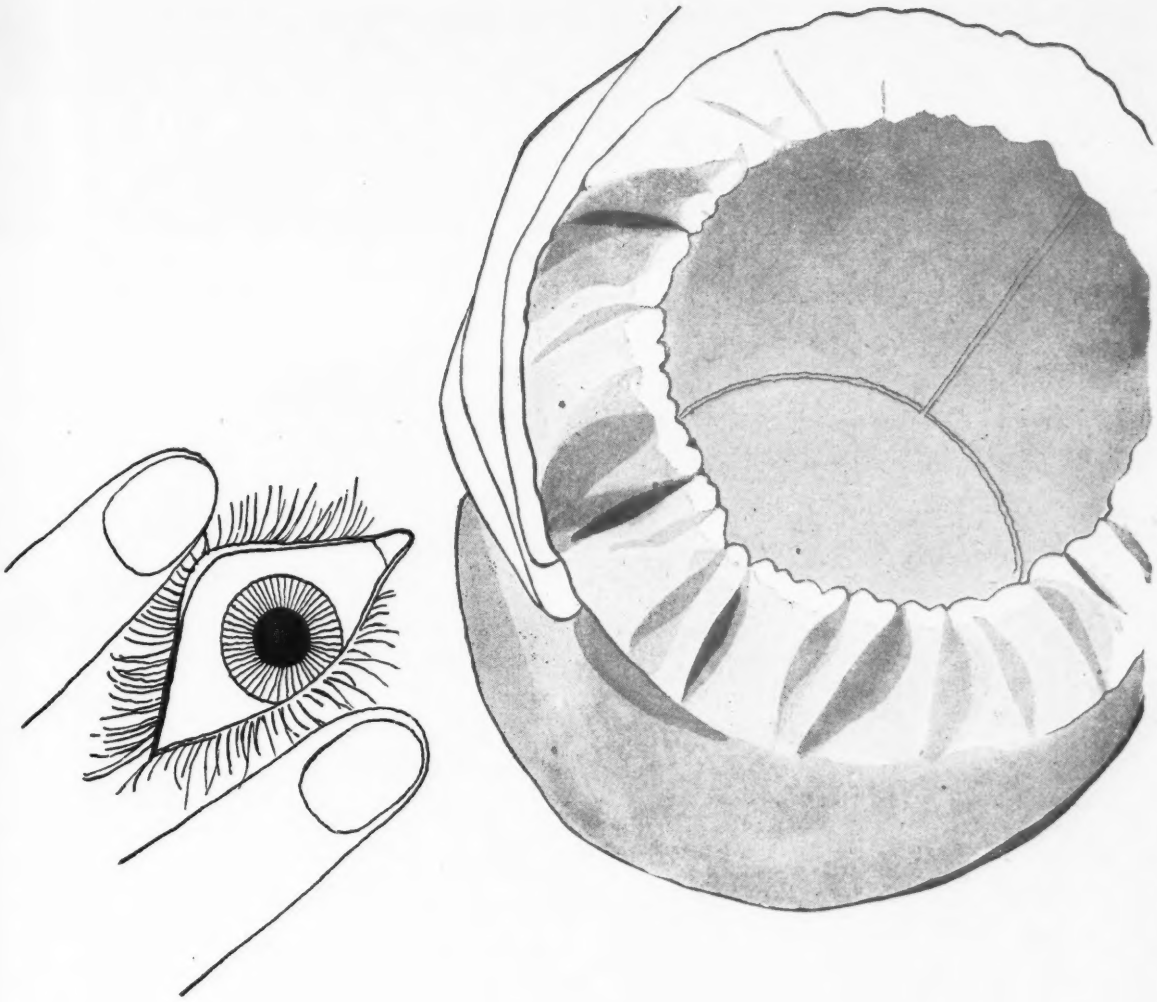
Conclusion

In conclusion I want to express a conviction. If a hospital is to continue to be a temple of service devoted to the alleviation of suffering we, as its administrators, must not lose our sense of values. We must not become unduly impressed with that twentieth-century god called Efficiency, as exemplified in the literature, in suave administrators' larger and better physical plants, shinier and more expensive equipment, organization and mechanization. If hospitals are to retain their fine traditions every employee must be motivated by a sincere spirit of service, and a consciousness of the "worth-whileness" of his task, accompanied by an attitude of modesty and dignity. These attributes must form the corner stone around which we build our superstructure.

"Thro' wind and tide One Compass guide
To that and your own selves be true!"

We cannot prevent the black birds of evil from flying over our heads, but we can prevent them from building their nests in our hair.

—Chinese Proverb.



92 years

For 92 out of the 100 years that ether has been used, the name *Squibb* has been synonymous with the finest and most advanced developments in inhalation anesthesia. Today, because of this, surgeons and hospitals the world over confidently trust the purity, uniformity and dependability of

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Is Recovery Delayed?

(Concluded from page 29)

recommended by Youmans are ordinary foods with high quality sources of protein supplemented by special feedings.

Desirable Inclusions

An excellent basis for a dietary history for every patient can be made by using the "moderate cost adequate diet" as suggested by Stiebeling:

Milk

One quart daily for each child (to drink or in cooked food).

One pint for each adult (to drink or in cooked food).

Vegetables and Fruits

Four and one-half to five servings per person daily.

One serving daily of potatoes or sweet potatoes.

One serving of tomatoes or citrus fruits.

One serving daily of leafy, green or yellow vegetables.

Three to five servings a week of other vegetables.

One serving daily of fruit.

Eggs

Two or three a week for adults, four or five for young children, a few in cooking.

Meat, Fish or Poultry

About five times a week, or daily if prepared in combination with cereals or vegetables.

Cereal

Daily—preferably whole grain.

Bread and Butter

Dark breads or breads made with enriched flours at every meal.

Dessert

Once a day, sometimes twice if desired and if it does not displace the protective foods.

Calories are very important in helping to maintain an equilibrium and to spare protein tissue, but they are not entirely sufficient. High quality protein is indispensable. Not only are calories and high protein essential in healing, but in undernourishment an ample supply of other nutrients, such as minerals and vitamins—especially the latter—is necessary. Mellanby has shown that a deficiency of vitamin A has led to bone overgrowth and degenerative changes in nerves and capillary fragility. Cannon discusses the need for adequate vitamin B, considering this as indispensable as the amino acids and calories. The large amounts of vitamin C retained by the body during the first period of burns and illnesses suggest the need for a markedly increased intake during this period.

Rose emphasizes that the body is remarkably accurate in its synthesis and that, in effective tissue building, the body must have available "all essential dietary constituents". To ensure availability of an adequate intake of these essentials, the surgeon must carefully prescribe the necessary diet and constantly check the food consumed by the patient.

Some surgeons feel that a patient cannot consume sufficient food to meet these post-operative needs. Nevertheless, a skilful dietitian can prepare milk shakes, custards and various formulae to supplement the diet and provide high protein and calories without requiring the patient to consume a large quantity of food and without the use of expensive supplements.

Bibliography:

Farris, J. M., Ransom, H. K., and Coller, F. A., Total Gastrectomy: Effects Upon Nutrition and Hematopoiesis. Surgery vol. 13; pp. 823-32; 1943.

Daughtry, Dewitt C., Newer Post Operative Trends, A. J. Surgery, vol. 70; pp. 374-82; Oct.-Dec., 1945.

Bensley, E. F., The Nutrition of the Surgical Patient, C.M.A. Journal, vol. 54; pp. 283-5; 1946.

Harrington, Mary M., Nutrition is the Cornerstone of Health, Harper Hospital Bulletin, vol. T; pp. 60-3; January, 1942.

Youmans, John B., Nutrition and the War, New England Journal of Medicine, vol. 234; pp. 773-83; 1946.

Thompson, W. D., Ravdin, I. S., and Frank, I. L.; Effect of Hypoproteinemia on Wound Disruption, Arch. Surg., vol. 36; pp. 500-08; March, 1938.

Lund, C. C., and Levenson, S. M., Protein in Surgery, J. of A.M.A., vol. 128; pp. 95-100; May 12, 1945.

Rose, W. C., Does the Amount of Food Consumed Influence the Growth of an Animal? Science, vol. 67; pp. 488-9; 1929.

Care of Roofs

(Concluded from page 68)

that is highly preservative can be made of the following mixture:

4 gallons of raw linseed oil
2 gallons of coal tar creosote oil
1 gallon of japan drier

The resulting colour, which is a medium brown, can be tinted, but only in the darker colours of creosote. Colour ground in oil is mixed with linseed oil to the consistency of paint; two gallons should be used with the foregoing quantity of stain. A liberal brushing with linseed oil will revive unfinished and dried out shingles. However, this application will not have a lasting effect.

Flashings are pieces of sheet metal that are used to close the gap between two roofing surfaces, between roofing and dormers, around chimneys, and at similar places not covered by roofing. Rustproof metal should be used, because of the expense of repairing a leak in a flashing. The upper edge of a flashing should be bedded deeply in a mortar paint and secured by mortar or roofing cement. Flashing around a chimney should not be cemented to the face of the masonry. When the flashings have begun to rust through, a coating of plaster roofing cement will prevent leakage. Flashings that are badly rusted should be renewed.

To repair breaks in roof metals, insert a piece of strong canvas into the leaky area of the gutter or roof drain. Before you do this, coat both sides of the canvas with white lead, then insert it in the gutter. If the leader leaks, wrap the canvas around the leader, holding the repair in position with a twist of wire or a metal band.

—C. A. March in "Buildings", Hospital Abstract Service.

Advisory Service for A.C.H.A. Members

The American College of Hospital Administrators has announced the establishment of an advisory and counselling service within the organizational set-up of the College. Hitherto information and advice has been given to those inquiring into the possibilities of hospital administration as a career. The extended service will be available to the entire membership. Men and women of long experience in the hospital field have been asked to serve as counsellors for the purpose of discussing, with the individuals concerned, professional matters of a highly confidential nature. Their observations may be of definite benefit in meeting serious personal situations.

Arrangements may be made through the office of the Executive Secretary by anyone affiliated with the College desiring to confer in confidence with a member of the advisory group.

What every Doctor should know about the

CONTINENTALAIR

ICELESS OXYGEN AND AIR CONDITIONING UNIT

There comes a time in every doctor's practice when a patient requires treatment which includes the administration of oxygen, other gases or the recuperating comfort of bedside air conditioning. When that occasion arises the physician in charge should know these important advantages of the Continentalair.

● **DUAL PURPOSE** The CONTINENTALAIR provides a quick and modern means of correctly administering oxygen therapy or providing bedside air conditioning. Within a few minutes, temperature is reduced to prescribed requirements.

● **ICELESS** No wasted time waiting for melting ice to reduce temperature. No disturbing of patient to replenish ice supply. No wide fluctuation of temperature.

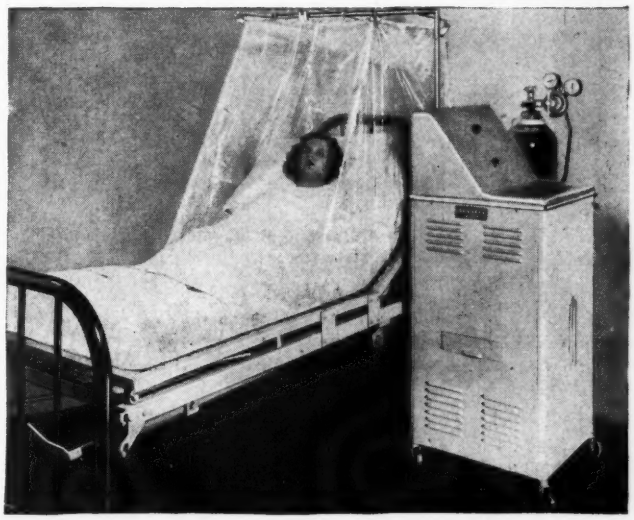
● **AUTOMATIC CONTROL** Simply plug into the electrical circuit, set the temperature indicator, and press the button. The prescribed temperature is then maintained automatically. Oxygen, when prescribed is regulated in the accepted practice.

● **CLEANS THE AIR** Air is water screened, to remove air-borne irritants. This may be especially valuable to allergy patients. Excess humidity is removed from the canopy to provide for restful comfort.

● **CORRECT CIRCULATION** Canopy air is completely changed every 15 seconds, thereby assuring the patient of a continuous supply of fresh, clean oxygen and air.

● **ECONOMICAL** Low electrical current requirements make CONTINENTALAIR an exceptionally economical unit to employ. Electric current consumption averages a few cents per day.

● **RELIABLE** CONTINENTALAIR is the only automatic iceless oxygen tent with a proven record of dependability. For more than 10 years, leading hospitals have relied on CONTINENTALAIR performance. Continentalair is 10 years ahead.



VISIONAIRE CANOPIES NOW AVAILABLE

Shown here with the CONTINENTALAIR is a VISIONAIRE **Disposable** Canopy. VISIONAIRE Canopies are **all clear;** the patient enjoys full visibility, thus minimizing the development of claustrophobia. VISIONAIRE Canopies are so low priced that each patient may be issued a brand new canopy to avoid any possibility of cross infection. Available in standard thickness or double thickness for extra durability. Immediate shipments for all makes and types of oxygen tents.

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THE Stevens COMPANIES

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What... No Soap?

NEUTRALUSTRE manufactures its own soap

● NEUTRALUSTRE

is NOT A SOAP but contains a RESERVE chemical which actually converts into fresh neutral soaps the very oils and other saponifiable soils on your floors. It utilizes powerful cleaning agents which simple soaps only waste in forming "curds and scum".

● NEUTRALUSTRE

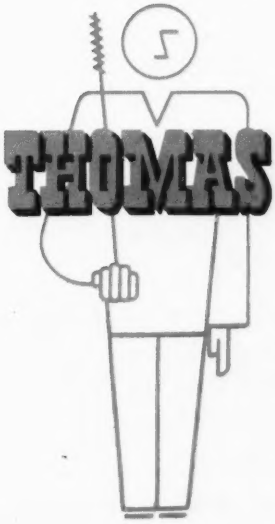
is a product we ask you to judge by appearance for the appearance of a floor cleaned with NEUTRALUSTRE is apparent and important to the user. NEUTRALUSTRE will later confirm your judgment by the "LONG LIFE AND HAPPINESS" test . . . long life of your floors, and happiness of your maintenance staff.

● NEUTRALUSTRE

the entirely new! Alkali-proof! Wax-free! Neutral! Efficient! and safe-and-sound CLEANER that requires NO RINSING . . . yet washes as it polishes and cleanses as it shines!

- ABSORBS ALKALI.
- Harmless to all materials.
- Remains neutral in solution.
- Retains efficiency in hard water.
- Dissolves instantly.
- Rebuilds its soap.
- REQUIRES NO RINSING.
- Does not streak or stain.
- Leaves no offensive odours.
- Leaves a polished appearance.
- Cleans quickly and successfully.

NEUTRALUSTRE has other properties contributory to its shining success in the SANITATION FIELD:



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TORONTO **MONTREAL**

Workshops will be Feature of C.N.A. Biennial Meeting this Year

The 24th Biennial Meeting of the Canadian Nurses' Association is scheduled for June 28th to July 1st, and will be held at Mount Allison University, Sackville, New Brunswick.

One of the features of the program this year will be the pooling of the experience and ideas of nurses across Canada in the form of workshops. It is planned to develop the activities of each workshop under the general direction of a consultant, assisted by two nurse leaders, all of whom have had wide experience in their particular field.

Members are expected to register for one workshop only, selecting the one in which they feel they would profit most. It is hoped that everyone will contribute to the discussions and give to the entire group the benefit of her knowledge and experience. The registration fee of $5.00 will cover the cost of the workshop booklets which will be provided for every member, and will also include the cost of any materials used for the workshops.

The first day, June 28th, will be given over entirely to the opening session of the convention, followed by the presidential address, reports from National Office staff and the *Canadian Nurse* journal, and an address by one of the workshop consultants in the afternoon. Workshops will be held the following day from 9 to 12 a.m. and continue through Wednesday and Thursday mornings, the afternoon sessions consisting of general meetings of the Association.

Another feature this year will be the arrangement and display of commercial exhibits.

The Association extends a special invitation to Schools of Nursing across Canada to plan to have at least one member of their student body attend the convention.

Further information concerning the convention will be given in the the *Canadian Nurse* journal and "Notes from National Office".

Hospitals and Research Foundations Receive Substantial Bequests

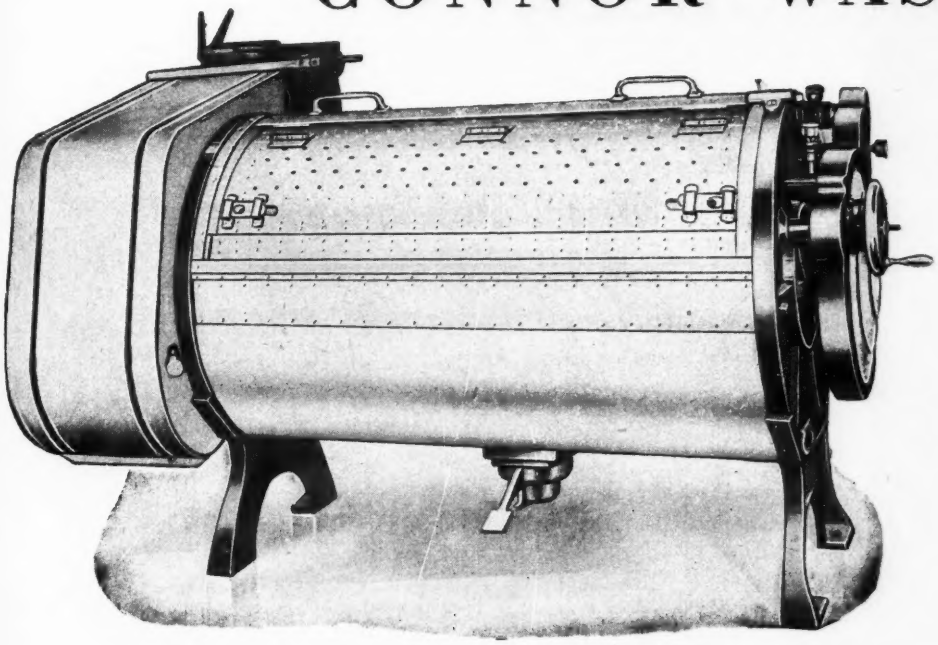
It has been announced that the residue of the estate of the late Kate E. Taylor of Toronto, which will amount to about $500,000, has been bequeathed to the Banting Research Foundation as an outright gift. The Canadian Red Cross Society also benefits under the will to the amount of $5,000.

Among the hospitals and other organizations receiving legacies from the estate of the late Jessie Niven, Toronto, are: Home for Incurable Children, $2,000; Queen Elizabeth Hospital, $3,000; Christie Street Hospital, $3,000; Hospital for Sick Children, $3,000; Canadian Red Cross Society, $4,000; Muskoka Sanatorium, Gravenhurst, $3,000. University of Toronto, for research in poliomyelitis, $5,000; Salvation Army, Toronto, $2,000.

Low Initial Cost — Low Operating Cost

Feature These High Quality All Metal

CONNOR WASHERS



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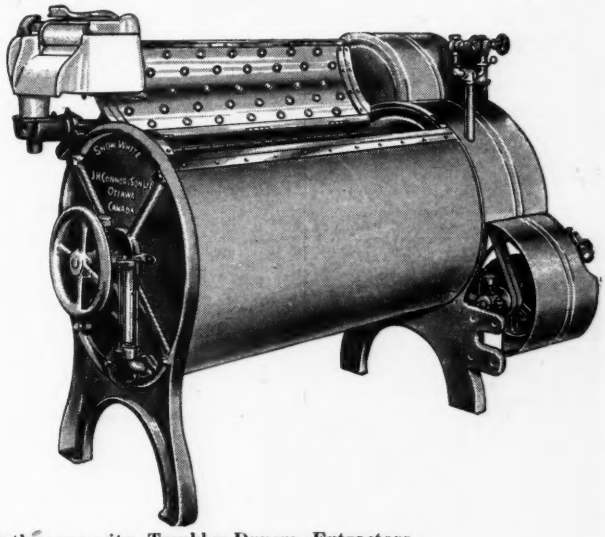
THE OTTAWA WASHER

No. 4 Ottawa Washer, complete with ¾ h.p. electric motor, single or three phase, 110-220 volt. Cylinder of hard brass, nickel plated and polished, 28″ x 48″. Capacity 40 sheets or 60 pounds dry clothes. Cylinder revolves on large, double race ball bearings, reducing power consumption 50 per cent. Weight 1,500 pounds.

No. 3 Ottawa Washer identical, but with 28″ x 42″ cylinder. Capacity 30 sheets or 50 pounds dry clothes.

THE SNOW WHITE NO. 2 WASHER

Complete with ½ h.p. electric motor and wringer. Cylinder 24″ x 40″. Capacity 22 sheets or 36 pounds dry clothes. Floor space 38″ x 64″. Weight 825 pounds. The greatest value ever offered for a metal washer of this size. Satisfied users from coast to coast.



Metal Washers from 36 to 150 pounds dry clothes capacity. Tumbler Dryers, Extractors, Ironers, Laundry Trucks. Write for catalogue and price list. Convenient terms arranged.

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WINNIPEG—242 Princess St. ***Quality Washers Since 1875*** **MONTREAL—4026 St. Catherine W.**

Fig. 1

Fig. 2

Fig. 3

DEEP MALLEOLAR ULCER

Healed with Standard Bandaging Technique

CASE HISTORY: C. J. Aged 45. Grocery Assistant. The patient first attended the clinic with a deep punched-out ulcer above the left internal malleolus . . . surrounding skin inflamed. (Fig. 1.)

TREATMENT: August 16th, 1946, Sulphanilamide powder was dusted into the ulcer, and calamine lotion applied to the inflamed area. An adhesive felt pressure pad was placed over the ulcer only, with a strip of "Ichthopaste" to cover the ulcer and the inflamed area. Elastoplast stirrups were applied and bandaging completed from toes upwards. (Fig. 2.)

September 27th, 1946. The ulcer and the devitalized skin area completely healed. (Fig. 3.) The patient was instructed to apply calamine lotion, pad of cotton-wool over the ulcer site, and to continue support with "Elastocrepe" for a few weeks.

DETAILS AND ILLUSTRATIONS above are of an actual case. T. J. Smith & Nephew Ltd., Manufacturers of "Elastoplast", "Elastocrepe" and "Ichthopaste", are privileged to publish this instance, typical of many, in which their products have been used with success, in the belief that such authentic records will be of general interest.

Elastoplast elastic adhesive bandages are available in widths 2", 2½", 3" and 4" x 5/6 yds. long when stretched.

Ichthopaste bandages are of the Unna's Paste type but contain 5% Ichthyol. The bandages are 3½" wide x 6 and 10 yds. long.

SMITH and NEPHEW LIMITED

378 St. Paul St. West **Montreal, P.Q.**

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The Burdick Approved* X85 and Contour Applicator

"the finest diathermy combination"

★ Canadian Department of Transport.
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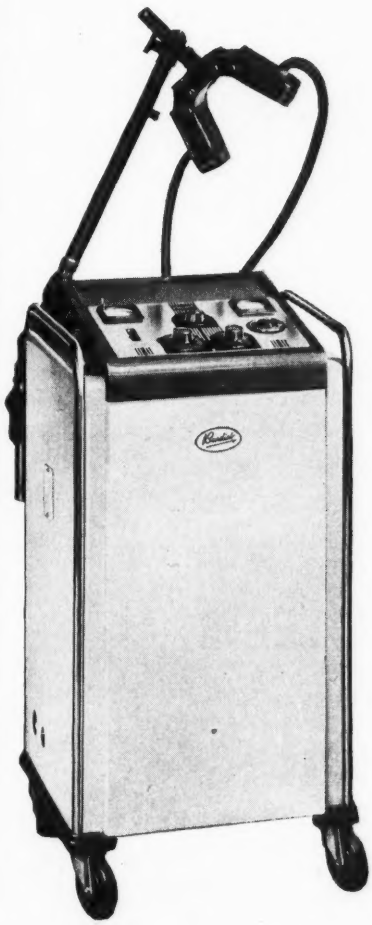
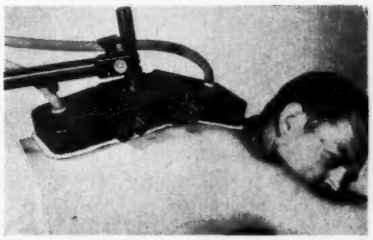
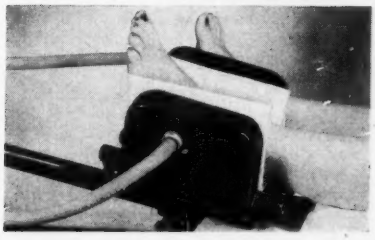
. . . . all necessary approvals in choosing the finest in diathermy units. For, grouped together, they represent acceptances by organizations with topmost standards . . . Truly, a unit winning these prompt acceptances, as the Frequency Controlled X 85 has, must be, as Burdick proudly names it, "the finest of diathermies."



Abundant Deep Heat While "Molded" to Body Contours





Continuous deep heating even while "molded" in the most angular treatment positions, are the two features of superiority of the Contour Applicator. And all because Burdick engineers use a continuous electromagnetic coil spiralled between the applicator's inner surface of new, flexible plastic and its five-section outer surface. At last, in a flexible applicator, temperature is ***even overall.***

To appreciate all the X 85 features, you must see it . . . We welcome you to our showrooms for a demonstration.

Before you buy, see Burdick and compare

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Eastern Distributors:
BURKE ELECTRIC & X-RAY CO., LIMITED, Toronto; CASGRAIN & CHARBONNEAU, LIMITED, Montreal; G. A. INGRAM COMPANY, LIMITED, Windsor.

Yellow Fever Inoculation Now Readily Available

According to a communication received from Dr. G. D. W. Cameron, Deputy Minister, Department of National Health and Welfare, yellow fever inoculation may now be readily obtained by those persons who wish to have a valid international certificate, acceptable to the quarantine authorities in foreign countries.

Immunity against yellow fever is recommended for all persons planning to travel in areas where the disease is either endemic or epidemic.

The vaccine is supplied free to Canada through the courtesy of the United States Public Health Service and the Connaught Medical Research Laboratories, University of Toronto. A number of agencies have been authorized to give yellow fever inoculations and these may obtain a supply of vaccine from the Connaught Medical Research Laboratory, Spadina Division, Toronto 4, Ontario.

The centres where such inoculation, and valid international certificates may be obtained are listed below, as arranged by the Quarantine Division of the Department of National Health and Welfare.

Halifax: Dept. of National Health and Welfare, Pier 21, P.O. Box 129.

Saint John: D.N.H. and W., Lancaster Hospital, P.O. Box 1406.

Montreal: C.N.R. Medical Clinic, 890 Notre Dame Street West, or D.N.H. and W., 379 Common Street.

Ottawa: Civil Service Health Division, D.N.H. and W., No. 3 Temporary Building, Wellington Street.

Toronto: Out-Patient Clinic, Department of Veterans Affairs, Second Floor, 55 York Street.

Toronto: The Connaught Laboratory, 150 College Street.

Winnipeg: Director of Pathology, Deer Lodge Hospital, Department of Veterans Affairs.

Regina: District Medical Officer, Department of Veterans Affairs, Regina Trading Co. Building.

Calgary: Out-Patient Department, Colonel Belcher Hospital.

Vancouver: Medical Officer in Charge, D.N.H. and W., Immigration Building.

WANTED and FOR SALE ADVERTISEMENTS

WANTED

One Additional Associate Director of Nursing Service Ottawa Civic Hospital, Ottawa, Ontario. 975-bed hospital, 250-300 students. Preference given to applicants with satisfactory professional and academic qualifications in addition to executive ability. Apply to E. G. Young, R.N., Director of Nursing.

DIETITIAN WANTED

100 Bed Hospital, Western Ontario. Apply stating qualifications and experience to the Administrator, Woodstock General Hospital, Woodstock, Ontario.

WANTED—SUPERINTENDENT

for new 32-bed ultra modern Winchester and District Memorial Hospital expected to open July, 1948. Send application to H. S. Gross, Medical Secretary, Winchester, Ont. Kindly give experience, age, religion, state of health and salary expected.

MALE ADMINISTRATOR

for Woodstock General Hospital, Woodstock, Ontario, a well equipped 100 bed institution. State experience and salary expected, also when available. Apply Woodstock General Hospital Trust, E. J. Hosack, President, Board of Trustees.

WANTED—MEDICAL RECORDS LIBRARIAN

immediately. Apply to Medical Arts Clinic, Regina, Saskatchewan.

WANTED—HOUSE SURGEON

for 70-bed hospital. Modern facilities. Apply stating age, qualifications, experience, and salary expected, to the Superintendent, New Waterford General Hospital, New Waterford, N.S.

FRACTURE TABLE FOR SALE

Roger-Anderson Fracture Table and Orthopaedic Table for disposal, with complete attachments. Used very little. For further particulars apply Children's Hospital, 250 West 59th Avenue, Vancouver, B.C.

FOR SALE

Sunkist Fruit Juice Extractor—D.C. 110 volts. Apply to Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal 18.

Please mention The Canadian Hospital when writing to advertisers.

A Recovery Room Saves Lives

A new departure in childbirth procedure — establishment of a "recovery room" — has been tried at the Millard Fillmore hospital in Buffalo with remarkable results.

A report on the first year of operation of the new system indicates that this may be the answer to the worst bugaboo of childbirth: haemorrhage, listed as the first cause of maternal death.

During the first year of the recovery room's operation, there were 3,215 deliveries at Millard Fillmore hospital, with not a single death from haemorrhage. In the previous five years, there were three or four deaths annually from this cause, a total of 16.

The first Buffalo hospital to install a recovery room in obstetrics, the Millard Fillmore has gained wide attention for the development.

The crux of the plan's success is that it provides a close watch on the new mother for eight hours—the dangerous period—after delivery.

Located alongside the delivery room, the recovery room is equipped with all the essentials to treating and halting haemorrhage, such as whole blood and plasma for transfusions, and glucose solution for intravenous injection. These are kept in refrigeration compartments close at hand so they may be obtained in a matter of seconds.

Immediately after delivery, each mother is taken to the recovery room. There she is checked every half-hour by a graduate nurse who is on duty at all times. A resident or intern checks again every hour. The nurse, well versed in post partum conditions, keeps very close watch, and in addition records on a chart the status of the patient in several particulars.

If the patient starts to haemorrhage, not a moment is lost. The nurse immediately calls the resident and the attending physician. The resident, in case the physician is out of the hospital, acts immediately to stop the flow of blood and gives a transfusion.

Whole blood is available in type 4-0 so that typing of the patient is unnecessary and no valuable time is lost.

"The whole point to saving a haemorrhaging patient is the time element," explained Dr. Lewis F. McLean, chief of obstetrics and gynaecology at the hospital. "In five or ten minutes a mother can go into a state of extreme shock and sink beyond rescue. We have to get them quickly. With the patient watched closely in the recovery room, this can be done. There is not the slightest chance that the beginnings of a haemorrhage will go undetected and neglected."

For the eight-hour period, the mother also is kept quiet and, except for necessary treatment, undisturbed. No visitors are allowed, not even her husband or mother who usually are permitted to see the obstetric patients in other hospitals.

—George Toles in "Hospital Topics and Buyer".

If the world were good for nothing else, it is a fine subject for speculation.

—Hazlitt.

Coming Conventions

May 9-13—A.C.H.A. Fourth Fellows' Seminar, Princeton, N.J.

May 17-18—A.C.S. Sectional Meeting and Hospital Conference, The Nova Scotian Hotel, Halifax.

May 17-21—A.H.A. Institute on Hospital Purchasing, Shirley Savoy Hotel, Denver, Col.

May 21-22—Canadian Society of Laboratory Technologists, McMaster University, Hamilton.

May 24-28—A.H.A. First Institute for Hospital Engineers, Knickerbocker Hotel, Chicago.

May 31-June 4—A.H.A. Institute on Public Relations, Westminster Choir College, Princeton University, Princeton, N.J.

June 16-18—Maritime Hospital Association, Algonquin Hotel, St. Andrews, N.B.

June 17-19—Canadian Society of Radiological Technicians, Chateau Frontenac, Quebec City.

June 21-25—Canadian Medical Association, Royal York Hotel, Toronto.

June 28-July 1—Canadian Nurses Association, Mount Allison University, Sackville, N.B.

September 16-18—A.C.H.A. Institute for Hospital Administrators, Chicago.

September 18-19—American College of Hospital Administrators, Traymore Hotel, Atlantic City.

September 20-23—American Hospital Association. Atlantic City Convention Hall, Atlantic City.

Week of Oct. 4th—Western Institute for Hospital Administrators, Hotel Vancouver, Vancouver.

Oct. 14-15—Saskatchewan Hospital Association, Saskatchewan Hotel, Regina.

Oct. 18-22—A.C.S. Clinical Congress, Biltmore Hotel, Los Angeles.

November 1-3—Ontario Hospital Association, Royal York Hotel, Toronto.

Nov. 10-12—Associated Hospitals of Alberta, Palliser Hotel, Calgary.

Health Care Plans

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in the surgical plan, and 94,269 enrolled in the medical plan.

The fifth annual report presented to the Board of Governors indicated a marked preference from patients for semi-private hospital accommodation, as 45.4 per cent of the 37,739 persons hospitalized during the past year had chosen to avail themselves of these facilities.

* * *

Ontario Blue Cross Broadcasts to West Indies

In a short wave broadcast to the West Indies, the Ontario Plan for Hospital Care, collaborating with the International Service of the Canadian Broadcasting Company, described the services of the Plan, and the part it plays in providing the people of Canada with prepaid hospital care.

The broadcast was one of six describing the health services of Canada and was made on February 18, by A. G. Ferchat, Assistant Director of Public Relations of the Ontario Blue Cross Plan.

Provincial Notes

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serve a wide area and it is hoped that construction will be commenced this year.

* * * *

LEAMINGTON. Excavation for the new $400,000 Leamington District Memorial Hospital was begun last month. This will be a 50-bed, T-shaped hospital of fireproofed, reinforced concrete frame and brick structure. It is hoped that construction will be completed this year.

* * * *

LONDON. Miss Ruth Thompson of Edmonton, Alta., has been appointed director of nursing services at Victoria Public Hospital. She succeeds Miss Hilda Stuart who retired recently after holding this post for the past thirty years.

* * * *

WINDSOR. At the Essex Sanatorium vocational classes for adults, and day school classes for children have been developed and expanded during the last six months. The forming of a school board has enabled the hospital to collect special grants from the government, and these classes are carried out in addition to the usual occupational therapy work.

* * * *

WOODSTOCK. Miss Helen Potts, superintendent of the Woodstock General Hospital for the past seventeen years, has resigned because of ill health. Her resignation was accepted with regret by the board who paid great tribute to Miss Potts and expressed the belief that the high standing of the hospital was due to her untiring efforts on its behalf.

British Columbia

GANGES. At the annual meeting of the Lady Minto Gulf Islands Hospital, the need for a new wing to accommodate children was stressed. The amount needed is $10,000, of which it is expected the Government will contribute one third. An all-out campaign for funds will begin in May but even before that a house-to-house collection will be taken.

* * * *

NANAIMO. Reports of the local campaign for funds reveal that there was a splendid response from the community and surrounding district, and more than the $10,000 objective was reached. The amount above the objective will be used for the purchase of new and vitally needed equipment for the hospital.

* * * *

TERRACE. A 10-bed Red Cross Hospital was opened at this village last month. In converted army headquarters on the banks of the Skeena, the unit will bring medical services to a scattered population of 1,300. It includes an operating room, x-ray department and case rooms. The supervisor is Miss Dorothy Jack, Reg.N.

* * * *

VICTORIA. It was announced recently that the mansion and five-acre property at 701 Sea Terrace has been purchased by the Sisters of the Love of Jesus, St. Mary's Priory, for use as a convalescent home. The old home is now being renovated, and will probably be opened within three months. It will remain in use until a large convalescent hospital can be built there. The Sisters announced that the project is the beginning of an extensive building program for the development of their work.

Hospital Printing Costs

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sider the manner in which the new form is to be used, how it is to be handled, how many persons will use it and how it is to be filed. The answers will suggest the general layout of the form.

For example, is the form for machine use, handwriting, looseleaf binders, mailing in envelopes, sorting or storing with other forms, or for microfilming?

One should question whether energy can be saved by making more than one copy, eliminating excess entries or material, use of abbreviations, eliminating writing by use of check marks, eliminating ruled lines, or altering sequence of information.

Before drawing the new form write down in correct sequence the information to be required and divide this into the three main sections which will appear on the forms as outlined above.

Having considered the purpose or purposes of the new form and the manner in which it is to be used, and with all of the basic information written down and in front of you, you are in a better position to actually draw your design for the printer.

Give attention to detail in drawing your form and measure your spacing reasonably accurately so that your finished design will be similar in appearance to the printer's finished product. Don't forget—the printer has not the advantage of all your knowledge when he starts in cold to do a printing job. If your design is a reasonable facsimile you will avoid having to examine more than one proof.

If the method of form design outlined above seems slow and cumbersome when compared to your way, bear in mind that you can save 30 per cent of your costs by this careful approach to the problem.

The choice of paper for a new form, bond, ledger paper or index bristol, will be determined by examining four factors:

1. *General Style*

Does your new form look like a letter, a history sheet, an admission card, a statistical statement or a charge voucher?

2. *How Long is the Form to be Used?*

Very few forms are retained more than three years—do not buy 20 year paper. If the form is to be handled many times use ledger stock, otherwise, it is in order to buy cheaper stock. A hard finish with erasive qualities is best for pen and ink; a bond paper for typewriter; and one with absorbent qualities for mimeograph work. If the new form is to be microfilmed, select your colour with care so that it will reproduce well.

3. *How is the Form to be Stored?*

If the form is to be filed in open throat vertical files, advise your printer of this so that he can cut the paper with a vertical grain to stand better in the files. If it is to be eventually filed in fixed or loose leaf binders the grain should run horizontally or away from the binding edge, and your stock need not be as heavy. On the other hand, if there is the possibility of considerable handling after routine use, as in the case of medical record cards, a heavier stock may be necessary.

4. *How Many Copies?*

All copies need not be of the same

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Hospital Printing Costs

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type of paper and you may run the gamut from onion skin to index bristol if the purpose of the copies so demands.

Be careful in the *selection of your paper stock* as large savings can be made on this item alone. Bond papers have a large ratio of strength to weight. Ledger papers have a better finish but their weight is greater than bond papers of comparable strength. Standard sizes are 17 by 22; 19 by 24; 17 by 28.

There are nine standard sizes that can be used for forms with the maximum of economy in your paper costs.

3 x 5	3½ x 4¼	7 x 8½
3½ x 8½	4 x 6	8½ x 11
4½ x 5½	5½ x 8½	8½ x 14

Index bristols are available in two sizes—22½ by 28½ and 25½ by 30½ to provide cards of the following commonly used sizes: 3 by 5; 4 by 6; 5 by 8.

Your hospital purchasing agent and your printer should both assist you in making your decisions with respect to the type of paper to be ordered.

Quantity to be Ordered

When the new form has been designed and the type of paper selected it is next necessary to decide upon the quantity to be ordered.

Many thousands of hospital forms are thrown out each year because they are obsolete. My advice with a new form is to go slowly. For an established form there should be a standard quantity to be ordered at each printing.

There are some hospitals that regularly purchase a year's quantity at one time on the mistaken idea that this is an economical method of purchasing. If you were to follow this policy you would find that you have too large an investment in printed forms in your inventory. From an investment point of view I would suggest that you purchase your quantities on the basis of the consumption for a quarter of a year or, at least, make arrangements with your printer to take deliveries on the basis of consumption for a quarter. It must be remembered that there are some forms which are not used in large quantities and you must buy for a longer period in order to get a satisfactory manufacturing quantity. This will not overload your inventories as these are the forms of least consumption.

Packaging. Have your printer package the forms in the quantities you would normally distribute to the using departments. This does not mean that they are to be packaged in 500's or 1,000's, as is normal. Broken packages lead to wastage and there is a saving to be made in packaging in 250's, 100's or even 50's, if that is your normal distribution quantity.

Avoid broken packages in your storeroom and you will save on the cost of your printed forms and find it an easier matter to take inventory.

Effects of Vitamin A

Dr. William J. Darby of Vanderbilt University, leading vitamin expert, recently said that vitamin A in excessive amounts is currently suspected of being a poison, causing haemorrhage, bone weakness and liver damage. The statement was made during a course on accessory factors in metabolism.

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